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ABSTRACT

Ten years ago the Institutes of Education and of Child Health of the University of London organized the initial meetings of what was to become a worldwide concept. A small team of pediatricians, curriculum designers and field workers from a variety of countries turned the key messages of primary health care into activity sheets for the Child-to-Child program which can now be found in national primary and community education systems in over 50 countries. Three basic assumptions underlie the program: (1) primary education becomes more effective if it is linked closely to things that matter both to children and their families and communities; (2) education in and out of school should be linked as closely as possible so that learning becomes a part of life; and (3) children have the will, the skill and the motivation to help educate each other and can be trusted to do so. This book offers discussions on the implementation and impact of the program, evaluates its future, and offers insights into the program's implications. Case studies are also offered. Appended are examples of materials and activities used around the world. (JD)

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CHILD-TO-CHILD
ANOTHER PATH TO LEARNING

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CHILD-TO-CHILD
ANOTHER PATH TO LEARNING

Hugh Hawes

This book has been written with
editorial assistance from **Georgina Page**.

Chapters 3 and 4 draw extensively from a
survey of Child-to-Child activities
undertaken in 1987 by **Tony Somerset**
and published by Child-to-Child in 1988.
In many cases the actual wording of the
survey has been incorporated into the text.

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FOREWORD

The first meetings to plan a Child-to-Child approach to health education were initiated in 1978 by the Institutes of Education and of Child Health of the University of London, ten years before the appearance of this monograph. To have inspired within that decade the range of active learning which is reported here is an outstanding achievement, and is due to the commitment and innovative thinking of both the co-ordinating team and many local organisers and participants.

Since 1972 the Unesco Institute for Education (UIE) has focused its work on the field of lifelong education. In the initial phase of our research and reflection in this field, the significance of alternative approaches to education and links between home, school and the community was stressed, and it can now be seen in the practice of Child-to-Child. It is for this reason that UIE undertook an analytical study of the Child-to-Child approach; the present monograph is an outcome of this effort.

Two of the principles of lifelong education are that the roles of teacher and learner are interchangeable, and that learning is not confined to the schoolroom. Child-to-Child provides arguments for the validity of both these principles, since it makes plain that children can become teachers of their community - of parents, neighbours and siblings - and that they learn and teach in many and varied settings. That schools can admit that they are not the sole repositories of knowledge and can welcome "outsiders" who are not primarily qualified as "teachers"; is itself a major step towards the realisation of lifelong education. One further advance that is signalled here is the possibility of producing and disseminating practical and effective teaching materials for a wide variety of agencies at very low cost.

Other publications by UIE report on many programmes of post-literacy and continuing education throughout the world, and on specific case studies of educational reform. The Child-to-Child message and materials on primary health care can be applied to all of these situations and have already been widely taken up and adapted. No one denies the danger of overloading the school curriculum, or the burden of domestic responsibility carried by children in many social environments, and it is therefore yet more important to see school education as a part, albeit a uniquely concentrated part, of a whole, lifelong process.

There are other dangers. One is that of over-centralisation with its concomitant announcement of targets, either of participation or of attainment. Equally, a lack of institutional support for local initiative and flexibility can vitiate any chance of success. Perhaps more difficult to overcome is the resistance of parents to messages sent to them via their children from an alien source, and most disturbing of all is the potential for misuse of this very method, for the malevolent "indoctrination" of children.

These problems are confronted by the author. In publishing this study, UIE anticipates that policy makers and educators will find much to admire and emulate in the methods of Child-to-Child, and much to reflect upon in the commentary on the relationship between children and adults, citizens and authorities.

Our sincere thanks are due to Hugh Hawes, and to Georgina Page and Tony Somerset, for making a most valuable contribution to educational innovation and debate. I am also grateful to my colleagues at UIE who have assisted in preparing this monograph: to A. Mahinda Ranaweera, who was involved in planning and implementing UIE's study of the Child-to-Child approach to learning, and to Peter Sutton and Inês Pennacca, who undertook the production work.

Ravindra H. Dave
Director
Unesco Institute for Education

Prelude

We Know a Child

"We know someone who is a teacher and a health worker. She looks after two children. One is four and one is two. She keeps them safe. She carries the little one and picks him up when he cries. She protects the bigger one from accidents. Yesterday when the little girl went too near the stove she scolded her. Today she helped her to cross the road and taught her how to watch for the cars.

She helps them when they are sick. She makes them comfortable, brings them food and keeps the flies away. Last month she saved the life of the little boy. He had diarrhoea and was very weak but she sat near him and gave him water through the day and long into the night. The little boy lived. Early in the year before the rains she noticed that the bigger girl had a sore on her leg. She took the girl to the medical post and the sore was cured.

She helps them to grow healthy. She feeds the little boy when he is hungry; she helps the little girl find sticks to clean her teeth. She teaches her songs to help her remember good health habits. She plays with the boy and she plays with the girl. As they play they learn to use their hands and bodies to try out things, to think of things, to imagine things. This teacher makes toys for them, invents games for them and tells stories to them. She teaches them words and how to sew words together.

Who is this teacher who does so much for her pupils and does it so well? She is their elder sister - and she is eleven years old.

We know a group of community workers who know every inch of the village in which they work, who are accepted by everyone, who want to help their community, who will work hard (for short periods of time) and cheerfully (all the time). Last month the health worker used them to collect information about which children had been vaccinated in the village. Next Tuesday some of them will help to remind the villagers that the baby clinic is coming and they will be at hand to play with the older children when mothers take their babies to see the nurse. Next month they plan to help the schoolteacher in a village clean-up campaign. These health workers are the boys and girls

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of the village.

We know a number of older teachers - ourselves. Many of us are schoolteachers, but some of us are health workers, religious teachers, craftsmen with a skill to pass on, and parents. Yet we are all teachers.

This book is written *for* us although it is *about* children and their health, and about children helping themselves and helping their young brothers and sisters.

It calls on us to recognise what children already do towards helping each other and helping us. It suggests ways in which we can support them and in which we can make their contribution more effective, easier, and more fun."

From *Child-to-Child*. Macmillan,
1979.

The Child-to-Child Logo

CHAPTER 1

CHILD-TO-CHILD: AN ALTERNATIVE APPROACH TO BASIC LEARNING AND BASIC HEALTH CARE

Primary Schools in Developing Countries ... Expectations

In 1985 over 80% of children of primary school age in developing countries[1] are recorded as attending primary school. Twenty years previously the figure would have stood at 60%.[2] Though these overall percentages average out great discrepancies and may conceal some optimistic interpretations of figures by governments, the percentage rise is nevertheless remarkable. For such enrolments have been achieved in the teeth of vast population growth and, in many parts of the developing world, stagnating or weakening economies. They represent a composite of efforts by nations, communities and individual families to provide school education for all children because of their collective belief that unschooled children are ill-equipped to take their places effectively and with dignity in an evolving world. All sorts of sacrifices are made to achieve such schooling. Governments curtail expenditure in other sectors. Communities provide materials and labour free. Parents sell livestock, eat less, work harder to send young children to school and maintain them there.

So much is expected of primary schools, particularly as it is only too apparent that in poorer countries they represent, for the majority of children, the only formal education they are likely to receive. Consequently those who design curricula set many noble aims for them. Children who leave primary schools, it is fervently hoped, will not only have their "minimum learning needs"[3] met, but will be given basic skills and understanding capable of improving their quality of life and that of the communities of which they are a part. They should learn to live in concord with their neighbours, preserve their environment, take charge of their own health and acquire productive skills to help them meet basic economic needs and to improve their living standards.

It is not only educationists who seek to use schools to further such goals. Those responsible for development in other fields, in agriculture, natural resources, health, labour, law and order, recognise that the school contains the largest single captive audience in the land and consequently that messages of development transmitted to the school and through the school to the community may be very effective.

... and Realities

Nobody anywhere would doubt the vital importance of school education for the survival and development of communities worldwide or question the potential of the school as a means of influencing the wider community, but those of us who are truly aware of the actual conditions in primary schools in poorer countries would confirm that a vast gap exists between these noble aims and the grim realities of educational practice. Very little thought of development priorities enters the mind of the average teacher struggling to survive in isolated and adverse conditions.

At first sight the reasons appear largely economic, for it can be argued that faced with an overloaded programme, a famine of educational materials, far too many children and a dearth of trained teachers, schools are incapable of providing any but the most formal type of rote learning. Beeby's phrase "good education costs more than bad"[4] is frequently quoted.

In fact the causes for the prevalence of inappropriate and unstimulating primary schooling are much more subtle. For combined with the inhibitions imposed by lack of means we have those imposed by lack of imagination. Here the forces of educational conservatism, which seek to measure educational quality by what we used to have rather than what we need now, forge an alliance with the forces of administrative expediency. The administrator likes to keep things tidy. He likes a simple, unified school programme backed up with a single set of materials and leading to standardised national assessment of competencies particularly designed to allocate places at secondary level. In this pattern any attempt to let schools vary structures, programmes or approaches to suit the needs of different communities creates a threat to uniformity.

To believe that the current crisis of achievement in schools, or the current irrelevancies in the programmes they provide, will just go away is to delude ourselves. In most nations economic and demographic trends rule out the possibility that per capita expenditure will rise. Nor will attempts to impose a return to programmes and standards of the good old days meet the challenges of the new. If schools, particularly primary schools, are to move towards meeting the development goals we seek they must undertake fundamental changes in the content they teach, the methodologies they employ and the relations they build up and maintain both with their communities and with the informal education which communities provide.

The Child-to-Child Approach

This study of Child-to-Child, an innovative approach to health education in primary schools, examines one way among many through which approaches to primary schooling may be changed. The approach rests on three basic assumptions:

i. That primary education becomes more effective if it is linked closely to things that matter both to children and to their families and communities (in this case their health and wellbeing);

ii. That education in school and education out of school should be linked as closely as possible so that learning becomes a part of life;

iii. That children have the will, the skill and the motivation to help educate each other and can be trusted to do so.

The Health Context

One of the most powerful messages delivered by what UNICEF now styles "The Child Survival and Development Revolution" is that there is a tragic record of human death and suffering caused not by lack of medicines but by lack of knowledge.

Nobody denies the effects of poverty and hunger on the health of populations, but nevertheless much suffering is preventable

- through better hygiene

- through better safety

- through knowledge of how to *prevent* killer diseases by innoculation and to manage them by techniques such as oral rehydration

- through better child care.

As with survival so with development. A child who receives proper mental stimulation from an early age, a child who is talked to and who is played with in its early years will not only grow up happier but is also more likely to achieve well at school.[5]

The Child-to-Child approach described in this study involves children, particularly those of primary school age, with the provision of such health care in school and at home. It identifies many ways in which they can help themselves, help each other, help younger children and through individual and joint action even help their families and communities. It examines how the school can help children to gain knowledge, skills and understanding about health care, how it can discuss action children may take, and can share children's experience at home back in the classroom. In so doing, children learn to link knowledge gained at school with their experience at home, and learn to apply and test that knowledge through practice. Additionally both they and their teachers are reminded of the responsibilities which they already possess in the home and towards other younger children.

Child-to-Child as a Path to Better Learning

The study also explores the way in which such approaches to health education may help to "unlock" better approaches to learning on a much wider scale. If children can form groups to discuss health priorities based on their own knowledge and experience, why cannot they do so in relation to other subjects? If an older child can help a younger one to practice better health habits, why cannot she help it to practice reading? If a group of children undertake a successful survey of the water sources for their community, why cannot the same skills of observation and recording be applied to the social studies and science curricula? If a health problem, say "recognising and preventing malnutrition", can help to integrate teaching and learning in mathematics (measurement), science (food values) and language (reading and writing about nutrition), why cannot such integration be applied to other issues that matter such as soil erosion or harmonious community relations?

One feature of the approach stressed throughout this study is that it is everywhere applicable. There is no community however isolated which does not wish to improve the health of its children or which would not benefit if schooling could help to achieve this.

There is no school however poor which lacks the resource of children, or whose children cannot co-operate to help each other.

There is no government however bureaucratic who would not wish its education and health services to work together towards development.

Child-to-Child is an approach for all seasons.

Content of the Study

This study describes the growth of the Child-to-Child idea and the network of health and education workers who are committed to spreading and developing it. In our third chapter we analyse the applications of the idea in the many countries in which it has been practised. In the last two chapters we look more closely at the value and potential of Child-to-Child. In so doing we discover how an approach which appears on first sight so desirable and so feasible leads towards many fundamental changes in the way we plan, design and deliver primary education - changes which may disturb or even threaten policy-makers, administrators and teachers.

Indeed the case of Child-to-Child illuminates sharply the basic dilemma which affects all those who contemplate translating the principles of lifelong education to policy and practice.

At the level of rhetoric everyone is in favour of it.

At the level of policy many are frightened by the upheavals which would be implied if rhetoric really became reality.

Yet in the longer perspective those who look far enough into the future are frankly terrified at the thought of leaving education unchanged. Certainly the prospect of allowing primary education as it exists in many less developed countries to follow its present path towards lower standards and increased irrelevancy is profoundly disturbing. New paths must urgently be sought and found. The Child-to-Child path may well be one worth following.

NOTES AND REFERENCES

1. A breakdown of the statistics is available in the World Bank's *World Development Report*, Oxford: Oxford University Press, 1987, and UNICEF's *The State of the World's Children*, Oxford: Oxford University Press, 1988.

2. For an analysis of the trends up to 1983 consult Fredriksen, B. "The Arithmetic of Achieving Universal Primary Education", *International Review of Education* 29(1983), No.2, pp. 141-153.

3. "Minimum needs in developing countries would normally be literacy, numeracy, adequate verbal expression, and some knowledge of citizenship and of the physical and social environment, of health and nutrition learned by methods which rouse curiosity, develop self-reliance, and encourage physical and mental adaptability." Phillips, H.M. *Basic Education - a World Challenge*. London: John Wiley, 1975, p. 180.

4. Beeby, C.E. *The Quality of Education in Developing Countries*. Cambridge, Massachusetts: Harvard University Press, 1966, p.33.

5. Very interesting research is described simply in Hampton, J. *Happy Healthy Children*. London: Macmillan, 1985.

CHAPTER 2

CHILD-TO-CHILD - HOW IT STARTED AND HOW IT GREW

The Ideas

The opening passage of the book *Child-to-Child*, published in 1979 and reproduced in our prelude, gives us a glimpse not only of the emphasis but also of the style of the movement.

The programme was launched in 1978, with very little money, but from the drawing room of 10 Downing Street (because it was supported by Mrs Callaghan, wife of the British Prime Minister of the day). Since then the ideas have spread to sixty or more countries in an uneven and somewhat haphazard way, still with very little money but always with the support of a network of concerned individuals which includes presidents and their families, top bureaucrats, paedriatricians and professors, doctors, teachers, health and social workers and most important of all the children themselves. It is a movement based round an idea, an association of people who are committed to that idea, but who perceive it, who disseminate it and who use it as they think fit and proper. It is this looseness, this flexibility, which gives Child-to-Child both its strength and its vulnerability.

Origins

Child-to-Child derives directly from the concept of Primary Health Care which had been gaining momentum during the 1970s due to pressure, not only *from* but also *upon* international agencies - initially the World Health Organisation and subsequently UNICEF.[1] David Morley of the London University Institute of Child Health, whose recent book *My Name is Today* [2] provides a graphic and moving analysis of the nature of the Primary Health Care concept, was one of a number of opinion leaders from round the world passionately concerned with the rethinking of health priorities and approaches which Primary Health Care embodies.

Primary Health Care involves:

- A commitment to redistribution of health care and health facilities, so that "health for all" can be achieved. Primary health care is based on inviting communities to define needs and seek to respond to them. Programmes need to be flexible and able to adapt to changing needs.

- An emphasis on preventive measures as a priority, and on health understanding by communities as a basis of prevention. The importance of preventive medicine is underlined in the developing world where access to health services is so limited, especially in rural areas.

- The demystification and democratisation of Medicine. Health care is seen not merely as the preserve of doctors, or even of the wider medical profession. Health care is seen as a common objective to which all can contribute and for which all community members are responsible.

- A broad concept encompassing the whole health and development of an individual. Thus, good health is not merely absence of disease; it is a state of physical, mental and psychological well-being. Health care in children involves care for their mental development and stimulation just as much as for their physical growth and nutrition.

- A partnership of all with responsibility for health in communities; thus modern medicine alongside traditional healing; development in agriculture, housing, sanitation, alongside development of health services. "Health is seen as a state of wholeness and well-being in which persons are able to work together to meet their needs in a self-reliant way" (Werner & Bower, 1984).[3]

The catalyst for the launch of Child-to-Child was the announcement of the International Year of the Child for 1979. In the preparation for it, David Morley, long convinced of the power of education as a vehicle of primary health care, approached a colleague, Hugh Hawes, in the University's sister Institute of Education. Could not an extra dimension be added to the concept of primary health care? Could not the power of children and the schools which educate them be more efficiently harnessed towards its ends? Could not those working towards primary health care take, in President Kaunda's words, "the great opportunity of enlisting hundreds and thousands of children in this same task"?[2] As Zef Ibrahim, also of the Institute of Child Health wrote,

> "The enthusiastic resource of children should not be allowed to be wasted. These activities when undertaken by children can act as Health Education through health action. The more involvement of children in health care of the other child of the family, the better is the result. Let a child act as a provider of primary health care of the family and to the community."

Finally, could not the two famous Institutes working together provide an example of how education and health workers at all levels could collaborate to achieve better community health through better education?

The First Networkers produce the First Materials

The activities of Child-to-Child during its first two years of operation are worth examining in some detail. The first priority was clearly to gather together a body of materials and ideas worth dissemination. The high and noble goal of using children as agents of primary health care is of little value unless someone decides and delineates which messages can be spread effectively and which cannot.

To this end, and after some preparatory work in London, a group of individuals were convened to identify such messages and describe them. The group, which met in workshops in London and Sussex in 1978, included nationals from 23 different countries and thus brought together a wide and diverse range of experience. There were professors of paediatrics, heads of national curriculum centres and units, specialists in primary methodology, as well as field workers from a range of different projects in education and health. The chair of the workshop was taken by the Deputy Director of the World Health Organisation (and former Vice Chancellor of the University of Ibadan) Professor Tom Lambo, but the whole proceedings were characterised, as all subsequent education encounters of Child-to-Child have been, by a great sense of informality, co-operation and commitment. All who participated in the work seemed equally motivated by the power of the idea and the desire to transform it into material and implementation strategies which would guarantee a lasting gain to the health of children.

By far the greatest contribution this group made was to identify and draft a number of key messages, which were finalised in the form of activity sheets and later incorporated with other material into a book, *Child-to-Child*, which appeared in time for the International Year. These messages were selected, and the draft activity sheets evaluated, on the basis of three main criteria:

i. Did the activities address important health priorities, central to the concept of primary health care - and were the health messages contained in these priorities clearly, correctly and unambiguously stated?

ii. Were the priorities selected those in which the power of children could be effectively used? Was there any danger of *misuse* by children? (Based on this criterion a number of messages, such as the importance of breast-feeding, were omitted.)

iii. Were the activities such as would engage the interest of children? Were they fun to do? (There was considerable concern expressed that in the name of Child-to-Child the responsibilities already undertaken by children could be made even heavier.)

The following eleven messages identified in 1978 have remained central to Child-to-Child:

The Message	*What children can do*
Personal and community hygiene and safety	
Prevent accidents.	Identity accident hazards and eliminate them. Watch and protect younger children (especially from home accidents, e.g. burns).
Care for teeth.	Protect teeth by good eating and tooth care habits. Pass on good habits to younger children.

Promote neighbourhood hygiene.	Be aware of unhealthy surroundings. Individually and together seek to improve them and teach other children to do so.

Prevention and control of disease

Oral rehydration saves lives of children with diarrhoea.	Recognise signs of dehydration. Mix a salt, water, sugar solution and use it.
Learn to recognise danger signs of illness.	Recognise danger signs, particularly of respiratory infection and high fever in babies. Seek help immediately.
Care for sick children.	Give fluids and feed a sick child. Keep fever down - cool it. (Much conventional treatment denies sick children food and wraps up children with high fever).

Child stimulation and development

Play and mental stimulation help children develop.	Recognise stages in the development of babies and young children. Learn to play creatively with them.
Toys and games can be made which aid growth and development.	Make toys for babies and younger children appropriate to their age. Help them to play with these.

Recognising and helping the handicapped

Children with sight and hearing problems need to be identified and their problems understood.	Recognise children with these problems. Learn simple tests for sight and hearing. Learn to help integrate children with these disabilities.

Better nutrition

Signs of malnutrition can be recognised and its causes understood.	Recognise signs of malnutrition in young children. (Arm circumference strips may be used.)
Better feeding is usually possible even though more money may not be available.	Spread messages about better feeding practices. Help apply them to younger children.

The messages contained in this list and spread through the book and activity sheets were important in themselves, but just as important was the style and pattern of involvement suggested. The messages, it was stressed, were intended to be spread jointly by health, education and community workers through many different educational encounters, formal to non-formal. They were suitable for schools and scouts, for extension programmes, for paramedical training, in fact for any channel through which it was felt children would be encouraged to help children.

Moreover, each message and each activity sheet tended to embody a certain methodology:

i. Understand the main message properly

especially its most important elements, e.g. Dehydration follows diarrhoea. Dehydration kills.

ii. Find out more about the problem

e.g. How many cases of diarrhoea?
What causes it?
How do people conventionally treat it?

iii. Talk over solutions

What can "I" do) to prevent diarrhoea, to combat de-
What can "we" do) hydration if another child is affected?

iv. Apply solutions

(Starting with learning the necessary skills)
Learn to make and mix the special drink.
Learn to give it to others.

Learn arguments to persuade others to accept the rehydration message.
Be prepared to take action and help if necessary.

5. *Seek to evaluate the effect of the message*

How many of "us" can make the special drink?
How many have passed on the ideas to others in our family and community?
How many of us have applied rehydration to children with diarrhoea?

As we shall discuss in a later section, such methodologies, when applied to formal education, take schools and teachers far beyond conventional didactic chalk and talk techniques prevalent in schools.

Dissemination

During the International Year of the Child the messages initiated in 1978 spread far and fast. Materials were sent or taken to many countries - there was no copyright on them, no restriction on their use and little guidance on how they might be used.

Consequently, and because of the impetus and publicity provided by the International Year of the Child, Child-to-Child ideas were taken up and used in various forms in many countries round the world; a postal evaluation carried out in 1981 showed activities undertaken by a variety of agents in some 48 countries. How these activities were being carried out and with what effect proved then, as now, far less easy to establish.

Child-to-Child - 1980-1986

By the end of 1979, the main issues facing Child-to-Child in London had become clear. They were in part dictated by the nature of the programme. Its core staff and funding remained tiny and though an International Committee had been appointed, it soon became apparent that to convene it regularly would not only drain available funds, but might even be of very questionable use, given the informal and highly decentralised way in which Child-to-Child had operated. Consequently, a London-based steering committee concentrated upon guiding and monitoring the growth and development of Child-to-Child in two main areas:

(a) The generation and dissemination of ideas and materials;

(b) The discussion and clarification of ways in which such ideas and materials can be effectively disseminated, their effects monitored and the resultant knowledge spread and shared.

Before examining these areas in more detail, it is worth considering how - even by 1980 - the original concept of Child-to-Child had widened and deepened. For it had become apparent that whereas the original concept of Child-to-Child had focused on the way in which the older children in a community could help to improve the health of younger ones, in reality the power of children to spread health ideas and practices could be and was being used in four ways:

i. Through the care they provide for younger brothers and sisters and other young children in the community (Child to Child);

ii. Through their influence upon other children in their age-group and community - especially those with less education and fewer opportunities than they have had (Children to Children);

iii. Through their influence as a group upon their own communities (Children to Community);

iv. Through their individual influence upon their families (Child to Family).

With this interpretation in mind, let us look again at the two main areas of the work.

Area 1 Ideas and Materials

Further major workshops were held in Britain and in Bellagio (Italy) to generate more activity sheets, together with relevant material for handicapped and refugee children.

In a separate writing workshop, eight story books were written, to link health ideas and the Child-to-Child approach with the needs and demands for interesting and relevant reading materials. Every effort was made to ensure that the stories, like the activity sheets, were interesting and provided fun as well as facts to children.

In a more recent initiative, material has now been written linking health education to mathematics.

Because Child-to-Child material was free and copyright-free, it spread rapidly in three ways:

First directly, through the use of the books and activity sheets widely and for many purposes.

Second through the translation and adaptation of the materials into many languages.

Third through the incorporation of large portions of the materials into books and manuals for health education, or into curriculum materials, training pamphlets, information hand-outs and periodicals, produced by governments, international agencies and voluntary bodies, international or local.

Table 1 on pages 16 and 17 gives some indication of the range and spread of Child-to-Child materials, and Appendix 1 indicates samples of the type of material generated and adapted.

The spread of these messages worldwide is impressive, the more so because information contained in our table is incomplete. There is little doubt that very large numbers of Child-to-Child messages have been and are being conveyed in materials and media not known in London.

Getting the Message Across

The range and apparent wide spread of the materials conceals many difficulties experienced in their design, adaptation and dissemination.

Creating new materials is a difficult task. Not only is the writing of concise, clear, simple messages a skill held by very few "experts" but there is also a fine balance between the production of materials which are understandable and materials which are innaccurate. Messages often need to be simplified in order to ensure that the information is widely accessible: hence medical language and terminology may have to be modified. However, accuracy of information remains essential.

Child-to-Child materials, by necessity, have had to prioritise health topics. There is a danger of overloading sheets

Table 1(a) Child-to-Child Activity Sheets Published in London 1979-1987

1. Personal and Community Hygiene & Safety

   Our teeth
   Looking after eyes
   Children's stools and hygiene
   Accidents
   Health scouts
   Our neighbourhood
   Clean safe water

2. Prevention & Control of Disease

   Care of children with diarrhoea
   Caring for children who are sick
   Early signs of illness
   Immunization

3. Child Stimulation & Development

   Playing with younger children
   Helping the non-school child
   Understanding children's feelings
   A place to play
   Toys and games

4. Recognising and helping the handicapped

   Handicapped children
   Let's find out how well children see and hear
   Helping the severely deaf child
   Polio

5. Better Nutrition

   More healthy food
   Growing vegetables in containers
   Feeding young children

   Translations of these sheets are available in French, Spanish, Arabic, Portuguese, Chinese, Telugu and Swahili.

Planned and In Preparation

Monitoring growth
Playing with babies (2 sheets)
Keeping a sick child interested
Smoking
Worms and parasites (2 sheets)
Sexually transmitted diseases

L'Enfant pour l'enfant - the French programme based in Paris - has produced 8 adapted sheets.

In India also, *Chetna (Ahmedabad)* and *VHAI (New Delhi)* have adapted and are producing activity sheets in Gujarati and Hindi.

Table 1(b) Other Child-to-Child Material Published 1979-1987

Translations of the Book Child-to-Child

Spanish	1979	Portuguese	1981	French	1984
Telugu	1979	Arabic	1983	Swahili	1986
Indonesian	1979			Sesotho	1987

Story Books

Following a writing workshop in 1980 a series of stories in graded English was produced and published:

Grade One: Good Food; Dirty Water; Accidents.
Grade Two: A Simple Cure; Teaching Thomas (Child stimulation); Down with Fever.

Six other titles in preparation

Pamphlets and Other Booklets

Child-to-Child published the results of its first evaluation in 1981 and has also produced other publications:

1981 Child-to-Child and the refugee programme (pamphlet)

1981 Do you know a handicapped child? (pamphlet)

1984 Child-to-Child - Health in Kenya (Activity book for British schools, OXFAM)

1988 Toys for fun (illustrated book) with preface in eight languages.

Child-to-Child in Other Publications

Child-to-Child material is incorporated widely into other books. The following have specific chapters devoted to it:

David Werner & Bill Bower: *Helping Health Workers Learn*, Hesperian Foundation, 1982

David Werner: *Disabled Village Children*, Hesperian Foundation, 1987

Beverly Young & Susan Durston: *Primary Health Education*, Longman, 1987

Child-to-Child material has also been incorporated into books, pamphlets and training material issued by International Agencies (Unesco; UNICEF; WHO), Bilateral Aid Agencies (British; German; Swedish), Interim and Voluntary Agencies (Action Aid; ICCC; Oxfam; Save the Children; Cafod; World Vision) as well as by many national governments and nationally-based voluntary agencies.

and books with too much information and of confusing the essential messages. However, there are often problems in this process of prioritising. The social acceptability of wording and messages needs to be considered. Do writers follow David Werner (Where There is No Doctor) and use the word "shit" because everyone understands it, or resort to euphemisms or complicated Latin words, such as faeces or excreta? Are materials related to AIDS explicit in their use of sexual language or do they talk of boys "going with" girls?

More unexpected for writers has been the problem of whether to include or leave out "conventional wisdom" in health education. "You must boil drinking water." "You must provide a balanced diet." In better conditions both are desirable - in desperately poor situations both are impossible. Those who draft Child-to-Child materials are acutely aware of this, but those who receive them are often unwilling to accept them if such conventional messages are not "up front".

Of course, from the outset, material centrally produced in London was designed to be translated and adapted not only to different cultures but to different levels and purposes. For it was recognised that such general material could not adequately suit the multiple audiences for whom it might be intended: health workers; teachers; adult literates; children in school; children reading it on their own. But in sober fact, adaptation presents many problems.

Translation of the material into other languages, with suitable modification of the pictures is, of course, an essential preliminary. But even simple translation presents problems. Not only are cultural contexts within language groups (say Spanish, Portuguese or Arabic) vastly different, but there are also political pitfalls. The translation of the *Child-to-Child* book into Spanish produced in Chile is unlikely to make much of an impact in Nicaragua, nor are the translations of the story books and activity sheets produced by a Christian voluntary agency based in Taiwan likely to cut much ice in Beijing.

Adaptation should accompany translation, but adaptation is not as easy as it seems. It requires very considerable time, commitment and expertise.

In some cases, sadly, materials have therefore been totally unchanged in translation, but most have indeed been slightly adapted, and in two cases there has been a fundamental recasting of the materials: French (for West Africa)and Gujarati (with further slight amendments in a later Hindi version). In Uganda a book was produced, written and illustrated by Ugandan teachers and their children.

Consideration of the adaptation of the materials leads us into a debate as to which materials are likely to prove most effective. Currently many alternatives are being tried and canvassed. The concept of Child-to-Child messages embodied in other more structured material for pupils and teachers (as in the very popular manual *Teaching Health Education*)[9] is naturally popular with curriculum centres. The idea of "readers" as a vehicle for health education has many protagonists - a story in graded language certainly serves the double purpose of teaching health and literacy. Aid Agencies like such cost-effective materials and seem, consequently, disposed to recommend the books warmly to governments. Radio programmes present another very attractive alternative of passing on Child-to-Child messages, particularly when they emanate from the children themselves; children's newspapers and comics are often favoured, but all these ideas are still gaining ground and the result of the 1987 Child-to-Child survey report, analysed later in this book, still identifies the activity sheets, especially those produced in the early days of Child-to-Child, as the most common and influential source of Child-to-Child ideas in both formal and non-formal education programmes. Yet the existence of a variety of media to convey messages seems nevertheless essential, the more so because it enables people to choose those which are most easily available to them and most acceptable to their learners.

Materials are not always used for the purpose for which they were originally intended. In Lesotho the Child-to-Child resource book translated into Sesotho will be used directly in schools. In Kenya the activity sheets were used as adult literacy materials in the Nairobi slums. In Tanzania the English readers, intended for use in middle and upper classes in primary schools, are used in secondary schools on the mainland and in nurse training courses in Zanzibar. In Pakistan the activity sheets form the basis for a children's page in a newspaper. But in every case, the messages reach the readers!

Area II Dissemination of Child-to-Child

Workshops

We have already described the appointment of an international committee. Despite the fact that it only met on two occasions, its members, together with those who had attended workshops in London, did a good deal on an informal basis to spread the Child-to-Child ideas in the countries from which they came.

In 1984 the French organisation, l'Enfant pour l'enfant, was innaugurated in Paris with the support of the International Catholic Children's Bureau. Dr Lucien Michon, a noted paediatrician, became its first director.

Both London, and subsequently Paris, looked on the stimulation and organisation of workshops and seminars as a major priority. Typically, a Child-to-Child seminar would be organised and planned at national level but with some encouragement and some funding from Child-to-Child. Its purpose, certainly in the initial years, was to bring the material developed internationally (and increasingly the story of how it had been used in other countries) to a national group of education, health and community workers, and so to stimulate discussion concerning how the ideas could be used and adapted, how locally relevant material could be generated and how working co-operation, particularly between Education and Health, could be ensured, both at local and national level.

One interesting feature of some workshops was that they brought groups together from the same country who had initiated Child-to-Child activities quite independently one from another and who were thus able to share ideas and experience.

Though Child-to-Child took a lead in the initial organisation of such workshops, it contributed no funds to subsequent follow-up. Those who participated either just "noted" the Child-to-Child activities and hopefully used the ideas gained in some of their programmes, or organised their own follow-up activities, large or small and at national or local levels, or in some cases negotiated help for the follow-up programmes from other donors such as the Aga Khan Foundation in India or UNICEF in East or Central Africa. By the end of 1987 Child-to-Child in London and Paris had assisted in funding some 32 workshops in 19 different countries, and a far greater number had been organised independently at national level.

No-one doubts the importance of the process of "talking through" responses to the Child-to-Child materials. Moreover, each workshop adds to the international experience. New materials and new strategies for dissemination are suggested, and these can be passed on. Someone has likened the Child-to-Child activities to a "bag of ideas", continually augmented, from which participants could select or reject what was useful to them.

But the experience gained from workshops is not without hard lessons.

In a number of instances major programmes have resulted. In one instance a whole nation (Zambia), with encouragement from its President, adopted Child-to-Child approaches in its schools. In many other countries, positive, though less widespread programmes have been initiated, but in some instances very little appears to have happened. The ideas failed to take root.

Workshops have also differed in style, from the democratic, informal and productive to the conventional forum where papers were read and few meaningful discussions took place. Predictably it was in such cases that little or no follow-up resulted.

Finally, workshops have varied greatly in the extent to which they managed to involve health and education in equal partnership. Rarely was full partnership achieved. Even more rarely could one point to a follow-up programme jointly planned and funded. It would seem that the achievement of true co-operation between Health and Education, particularly at higher levels, poses one of the greatest challenges to Child-to-Child.

Action Projects

Only a proportion of Child-to-Child projects have derived from workshops. Others started independently. A few, such as the "Little Doctor" Programme in Jakarta, started quite separately from Child-to-Child, yet found themselves closely associated with its aims. Clearly it was important for Child-to-Child in London and Paris to catalogue, describe and monitor such activities. Manifestly however, such action was beyond its capabilities.

Consequently, the extent and nature of Child-to-Child activities were and still are imperfectly known. What is very clear, however, is that the agencies who take up Child-to-Child, both government and voluntary, vary greatly not only with regard to how they use it but also in the degrees of visibility of the material and approaches.

These range from the very visible - where there are identifiable Child-to-Child workers driving landrovers emblazoned with the name and logo - to instances where the material has quietly infiltrated into national and local programmes. Visibility does not necessarily correlate with the importance of the approach.

Therefore it is apparent that there are very different styles of Child-to-Child project. Often more than one pattern may be in operation within a single country. The following variations exist:

i. "We have a Child-to-Child programme"
In a minority of cases there are specific Child-to-Child associations or co-ordinating offices with designated staff, sometimes full time.
Examples: Botswana, Uganda, Guatemala, Burkina Faso.

ii. "We have a Child-to-Child component in our programme"
In other cases Child-to-Child components of health and education programmes, specifically identified and named, exist within established programmes and structures.
Examples: Zambia, India (New Delhi and Bombay), Chile, Sudan.

iii. "We have Child-to-Child ideas in our programme"
The Child-to-Child approach, or parts of it, may be specifically recommended within existing programmes in health and education and/or Child-to-Child materials may be officially recommended for use.
Examples: Tanzania, Zimbabwe, Indonesia (Medical Training), Papua New Guinea.

iv. "We have discussed Child-to-Child approaches and found them useful"
Again, Child-to-Child initiatives may have been presented and discussed by national groups of education and health workers who then subsequently used them to a greater or lesser degree in the planning and implementation of their programmes.
Examples: Lesotho, Nigeria, Malaysia (Sabah), Philippines.

v. "I have used Child-to-Child approaches in my work"
Finally, the approaches may be used with varying degrees of modification by individuals, local voluntary bodies and institutions. As our survey described in Chapter 3

indicates, there are examples of such "take-up" in nearly all the countries in which Child-to-Child approaches are known to exist.

Sharing Information - Child-to-Child as a Network

The area of information exchange is one which Child-to-Child considers potentially vital.

Presently the London office has a wealth of resources in terms of material on health education, access to experts offering guidance and support, and extensive file data from correspondents throughout the world. Yet whilst the office endeavours to utilise these resources to greatest effect, sharing information and materials, to date this role has not been as full as it might be because of the lack of funds and available staff.

Some activities have taken place. A newsletter is published periodically and widely distributed. A travelling exhibition was mounted by the British Council and shown in 33 countries. Files are kept on all information received, and these have proved invaluable in, for instance, identifying a population for our recent postal survey. But there remains far more to be done.

Child-to-Child - the First Ten Years

Considering the size of the input, the output of Child-to-Child during its first years of operation was impressive.

At no time during these years were more than two staff employed at the central office in London, the director (part-time) and a full-time secretary. The Paris office ran on the same scale. The whole budget of the London office amounted to less than the salary and allowances of a single Unesco expert. All other contributions in time and expertise appear to have been given free.

But, of course, such appearances conceal a complicated pattern of give and take. Child-to-Child's success has depended on the co-operation of the bodies which support it and who have cheerfully accepted that their senior staff spend considerable time engaged in Child-to-Child activities. Because of what it has achieved over the years, Child-to-Child has brought credit to institutions such as London University, the British

Council, UNICEF, WHO and many others, but only because such agencies have been, from the inception, committed to the idea and supportive of those who sought to make that idea a reality.

NOTES AND REFERENCES

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3. Werner, D. and Bower, W. *Helping Health Workers Learn.* Palo Alto: The Hesperian Foundation, 1982.
4. Kaunda, K. Address to Child-to-Child Seminar, Lusaka, 8th July 1986.
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6. A smaller group of 17 writers met initially in London for three weeks. Their draft material was presented to a larger conference of 37 participants chaired by Dr Lambo in Fittleworth, Sussex on 16-20 April 1978.
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CHAPTER 3

THE NEXT TEN YEARS - CURRENT IMPACT AND FUTURE PLANS

With the appointment of a new director, John Webb, in 1984 Child-to-Child began the very serious process of rethinking its future in the light of its experience over the previous seven years. Several trends had already become apparent, of which the first two have been mentioned:

The first of these was the *widening of the concept*, from sibling care to "child power".

The second was the very *varied styles of operation* of those who used the Child-to-Child ideas and materials. In this respect it seemed clear that those who absorbed Child-to-Child ideas, rather than establishing overt and separate Child-to-Child programmes and projects, needed to be encouraged. There was, of course, nothing intrinsically wrong with such projects - and many did marvellous work - but the tendency to build fences round them and hence create rivalry and raise animosity was also noted. Hence the phrase "Child-to-Child programme" was and is consciously discouraged. Child-to-Child prefers to see itself as an *approach* or a movement.

The third trend which had become apparent was the very evident *educational nature* of Child-to-Child. Its origins had been in health and many of its first activities had been initiated outside schools. Increasingly, however, we saw its activities concentrating on schools - and within the formal school system. This had manifest advantages since schools include by far the largest mass of children, but there were also dangers. The strength of Child-to-Child lay in its diversity - the way that its messages could spread across and beyond sectorial boundaries and formal systems. It was vitally important that this flexibility be maintained. In one African country with a tragic recent history the school children have invented a new slang word, "to coup", meaning to take over by force (e.g. "he couped my football!"). It is essential that the formal education system be prevented from "couping" Child-to-Child.

The fourth trend observed was *the tendency for plans and activities to broaden out* from the original conception of child power in primary health care to the wider, almost limitless, fields of child power in relation to education and development. If children could help each other and their communities achieve better health, could they not equally promote environmental improvement; better food production; better community relations; moral regeneration? Could Child-to-Child approaches in health not extend to other areas in the primary school programme and onwards and upwards to secondary schools and teachers' colleges?

The answer to all these questions was, of course, "yes", but as the small co-ordinating groups of Child-to-Child in London and Paris contemplated the implications of this in relation to Child-to-Child's capacity to initiate material, stimulate dissemination and organise information and feedback through its network, they felt distinctly inadequate.

In the face of such rethinking, two major decisions were taken: the first to commission a review of Child-to-Child activities[1] and the second to plan a modest and controlled expansion of Child-to-Child staff and programmes.

The first task, as all appreciated, was one which would be exceptionally difficult to accomplish either fully or to everyone's satisfaction. Child-to-Child activities were so diffuse, information concerning them so scanty, objectives and expectations so diverse that to evaluate Child-to-Child's extent and impact (which is what many donors would have liked to see) was impossible. However, the survey which emerged substantially increased and deepened knowledge about Child-to-Child and provided an invaluable baseline from which future planning could depart.

Such planning, however, involves no fundamental change in the direction of Child-to-Child. It will remain, as before, a network, a movement committed to help the generation, spread and exchange of ideas. It will never seek to become an agency involved in funding or managing its own projects. Such a role would run totally contrary to the spirit in which it was conceived and has operated over the past decade.

Now a Trust, and still firmly associated with the Institutes of Child Health and Education, Child-to-Child plans in the next five years:

- to revise, augment and diversify its core materials, which will involve moving out from print into audiovisual material;

- to continue to stimulate and monitor implementation, a process likely to include a considerable programme to classify and monitor approaches now identified in many countries;

- to build up a more detailed and more effective system of information exchange.

All these activities are, of course, open ended. There is an almost unlimited amount which could be done in each field... but as the old French saying goes "The most beautiful lady in the world can only do the best she can."

Child-to-Child in Action 1987

The survey completed in December 1987 represented, as we have already mentioned, a very able and illuminative response to the impossible question "How is Child-to-Child doing?"

It is conceived in three parts; a postal survey which we shall now consider, a series of case studies, two of which are included in our next chapter, and an interpretative analysis.

The survey of Child-to-Child "projects" reveals 114 in 39 different countries (including India with 23 projects). Additionally from Child-to-Child records it is possible to identify a further 18 countries with one or more projects. Table 2 lists countries where initiatives are known to exist in 1986. This is very certainly a conservative figure. Response to postal questionnares depends on the respondent receiving the communication, having the time and the language to answer it, and on the answer actually reaching London. Hence it is not at all surprising that workers in Tigre (where Child-to-Child materials have been translated) failed to respond or that nobody in Indonesia or Sudan (where important programmes exist) found the motivation to reply in English to the questions. An informed guess might suggest that there were about 150 - 200 projects (mostly small) "up and running" in about 60 countries.

But the word "project" is also restrictive. It implies that someone is both using the Child-to-Child material and readily identifies it as such. But in addition to such people we

Table 2 Countries where Child-to-Child Programmes and Approaches are Known to Exist (1988)

* Indicates more than one known example

INDIAN SUBCONTINENT

Indian States:

Andhra Pradesh*
Bihar
New Delhi *
Kerala*
Rajasthan
West Bengal
Uttar Pradesh
Gujarat
Mahrashtra*
(Including Bombay)

Other Countries

Pakistan*
Nepal*
Bangladesh*
Sri Lanka
Bhutan

SOUTH AND EAST ASIA AND THE PACIFIC

Taiwan
Philippines*
Indonesia*
Thailand*
Malaysia*
Papua New Guinea*
Fiji*
Solomon Islands
Australia

ARAB STATES

Sudan
Djibouti
Oman
Saudi Arabia
Lebanon
Syria
Egypt

AFRICA

West Africa

Nigeria*
Sierra Leone*
Liberia
Togo
Zaire
Cameroon
Ghana*
Burkina Faso*
Senegal
Niger
Benin

East, Central & South

Zimbabwe*
Zambia*
Botswana*
Kenya*
Rwanda*
Uganda*
Angola
Malawi
Somalia
Lesotho
South Africa*
Tanzania*

AMERICA

Brazil
Grenada
Jamaica
Haiti
Costa Rica
Paraguay
USA
St.Vincent
Guatemala*
Honduras*
Chile
Mexico
Peru
Colombia

would fervently hope that there were many others who had benefited from Child-to-Child approaches because they had infiltrated into syllabuses, into teachers' materials such as "Teaching Health Education" or "Disabled Village Children"[2] or because they had listened to the radio or read the Child-to-Child stories. These are the "invisible earnings" of Child-to-Child.

Hence the survey of Child-to-Child projects must be seen for what it is - the best it was possible to do given the nature of the programme and the time available both to the evaluator and the respondents.

The survey was very carefully carried out. All those who had responded to the 1980 questionnaire and all those who had written to the Child-to-Child office between 1983 and April 1987 asking about Child-to-Child or requesting Child-to-Child materials, or reporting activities were contacted. In all 548 individuals were contacted and 139 (25.5%) replied, a very satisfactory response but obviously not nearly high enough to justify using the sample statistics to make population estimates.

The full survey report is published and repays reading. Here it is only possible to give an abridged version of the information it revealed, (though we have, for the most part, retained the original text of the report). We consider:

- the different types of activity undertaken under the name "Child-to-Child";
- who initiates them and where;
- which messages were preferred;
- numbers involved;
- strengths and weaknesses of the Child-to-Child approach revealed by the survey.

Different Types of Project[3]

The survey identifies three categories of project:

Outreach projects (41%)
where children use their knowledge and activity to help others

Enquiry projects (28%)
where children use Child-to-Child materials and investigations mainly to acquire knowledge which they will use later

and Other projects (40%)
making use of Child-to-Child materials (usually directed at adults or older children).

Within each of these categories (which certainly overlap) there are a number of variations.

Outreach Projects

Here are five of the projects coded as outreach. (Statements are edited versions of questionnaire responses.)

1. "The teachers trained the children in their classes in appropriate health topics. The children practise the activities with their classmates, the lower-grade students, and brothers and sisters in their households. The pupils also work with the rehabilitation workers training handicapped children and non-school-going children."

   Nepal

2. "Children in classes 4, 5, and 7 are taught at school how to prepare the rehydration drink for children with diarrhoea. They then help the nurses at the public health centre in teaching nursing mothers how to prepare this drink. In consequence, fewer babies now die from dehydration."

   Sierra Leone

3. "The headmaster, teachers and pupils in our (primary) school have joined hands to help the children in a handicapped school which is in our community. We have made crutches for the handicapped children who need them. Our children enjoy working with the handicapped children, and the handicapped children enjoy learning with normal children."

   Kenya

4. "We held a children's poster rally which had a good impact on the society. As a result, in the immunisation camp which we held as a follow-up, nearly all the children got immunised."

India

5. "Here in our state we have no programme called Child-to-Child. We have a day care centre and a primary school. The children have made brooms from palm fronds to sweep their homes and their classrooms. They have grown plants in containers and learned that if you don't feed living things they will die. They have learned songs about immunisation and ORT, and acted some plays to entertain their parents. We also use these children as a medium to reach the parents so that they attend the Family Planning Clinic. The kids have been doing wonderfully..."

Nigeria

The wide-ranging character of children's outreach activities in Child-to-Child projects will be evident from these examples. Children work as health communicators (Nos 4 and 5); they work with adults, essentially as health assistants (Nos 1 and 2); they work as a group with other, less-privileged children (No 3) and they work to improve the quality of their physical environment (No 5). In some of the more complex projects, children take part in outreach activities of several quite different types.

The last example quoted deserves special notice. The initiator does not call the project she is running 'Child-to-Child'. The reason may be that although the project involves a wide range of learning and outreach activities, it does not include a component in which children work specifically for the benefit of other children. There is in fact quite a widespread tendency to regard the phrase Child-to-Child, and the logo which usually accompanies it, as a prescriptive definition rather than as merely a convenient label for a set of varied projects, sharing little more than a common approach to the health education of children.

Enquiry-based Projects

As a group, the 'enquiry-based' projects are more homogeneous than the 'outreach' projects. Essentially these are projects in which the purpose of activity is to enable children to find out more about health issues through observation, investigation and analysis. If the children leave the classroom, it is to gather information rather than to intervene. Of course, any well-conceived activity programme is concerned to facilitate the application of the knowledge and skills children acquire at school to out-of-school situations; but application is regarded as a consequence of effective education, rather than as an immediate goal. Here are two examples:

1. "As a schoolteacher I and my colleagues have used Child-to-Child materials in Health Education to advance children's knowledge through reading and through activity. The children were involved in carrying out experiments and in collecting data and other records. Since these activities are child-oriented it gives them a chance of self-discovery."

   Fiji

2. "The activity sheets were used to teach children how to maintain a better standard of health. I have made stick brushes and used them to teach children to clean their teeth if toothbrushes are not available. We have run field trips to the market, post office, hospital etc., and children were taught how people work always to keep these areas clean."

   Sierra Leone

Other Projects

The projects which make up the third group are the most diverse of all. The only attribute they share is that they all employ Child-to-Child materials in some way or other.

In some cases, the materials have been used in schools to strengthen the content of traditional health education courses, but without the adoption of enquiry-based or outreach approaches:

"I used the activity sheets at secondary school during

> biology. They have helped me a lot. The pupils don't participate in the activities due to lack of time. They only borrow the activity sheets and read them. Primary school teachers have also found them useful in science and health education lessons."
>
> Malawi

In other cases, the materials have been used outside the schools but within other parts of the formal education system, for teacher education or the development of new curricula:

> "Our teacher education students use Child-to-Child materials in their studies for a basic course in special education, which includes early stimulation, and the detection of auditory and visual problems."
>
> Honduras (original in Spanish)

> "Child-to-Child activity sheets were used in the preparation of science, agriculture and health teachers' guides, funded by the World Bank First Education Project. They were useful because they gave us *ideas* as to how to make health topics interesting."
>
> Solomon Islands

A third major use has been in health education projects designed mainly for adults rather than children:

"Child-to-Child activity sheets have been used by community health workers in a village-to-village health education programme. Special attention is paid to different groups within each village: women, men, and the elderly. Children are also included as so few children attend school in these areas."

Zambia

"Child-to-Child materials were used in the training of trainers for the under-six clinic programme, and for programmes for mothers. The word 'child' was often changed to 'mother', and we developed new materials on breast-feeding, rooming-in, the care of the newborn, etc."

Philippines

Who initiates Projects and Where

The survey divided the origins of those who initiated projects into five main groups as indicated in Table 3.

Table 3 Initiators of Projects

Teachers	25		25	22%
Other formal educators	15		15	13%
Doctors	15)	Health workers	36	32%
Other health workers	21)			
Extension workers	29)	Non-formal educators	33	29%
Youth group leaders	3)			
Other social workers	1)			
Private individuals	5		5	4%
TOTAL	114		114	100%

Teachers. All teachers in formal schools, both government-maintained and private, are included in the group.

Other formal educators. This is a more heterogeneous group. It includes educational decision-makers of all kinds: education officers, school inspectors and advisers, curriculum planners etc. Essentially, these are people with power to bring about changed policies in formal schools. The group also includes teacher educators and university lecturers in non-medical faculties.

Doctors. Lecturers in university medical schools and other medical training institutions are included in this group.

Other health workers. These are mainly workers in primary health centres and dispensaries.

Extension workers. This is again a heterogeneous group, consisting of all trainers and extension workers who do not work in formal education or health care. They include social workers, adult literacy workers, and co-ordinators of women's groups. We shall use the umbrella term *non-formal educators* to refer to extension workers plus youth group leaders working in organisations such as the Scouts, Guides and Red Cross.

Private individuals. These are people who have run projects entirely in a private capacity, without a relevant professional background. Two of them are parents who set up Child-to-Child projects for their own children:

> "I and my wife read the activity sheets and used the information we got in caring for our three children, aged 10, 7 and 3 years. They were involved in some of the activities: looking after the eyes and teeth, caring for the sick, etc. We found the materials involving the promotion of personal hygiene, the control and treatment of diarrhoea, the prevention of accidents, and child feeding, most useful."
>
> Ghana

It can be seen from the table that the project initiators come from formal education, non-formal education and health backgrounds in approximately equal numbers. Teachers in formal schools make up 22% of the total group.

The survey grouped the institutions where the main project activities are located into eight categories, and then combined some of the smaller categories to give larger numbers. Details can be seen in Table 4.

Table 4 Institutional Location of Projects

	n		n	%
Formal schools	55		55	48%
Primary health centres	13)	Health institutions	17	15%
Other health institutions	4)			
Non-formal schools	14)	Non-formal education institutions	32	28%
Community schools	11)			
Youth groups	7)			
Non-institutional location	9		9	8%
Not stated	1		1	1%
TOTAL	114		114	100%

By far the commonest institutional location for the projects in our study is the formal school. As many as 55 of the 114 projects we surveyed, or 48%, are based mainly in schools. Non-formal educational institutions of various types provide the setting for a further 32 projects (28%); followed by health institutions with 17 projects (15%). Only nine projects (8%) have no institutional base.

A striking trend in the results of the survey was the discrepancy between the number of projects set up in schools and the number of projects initiated by teachers. For every project initiated by a teacher, there are more than two projects set up in schools. This pattern must mean that there has been a substantial net 'migration' of non-teachers into the formal schools to initiate the projects we are surveying. There are far more health workers and non-formal educators running projects in the schools than there are teachers running projects in other institutions.

These 'initiator migration' patterns are quite complex. The details can be seen in Table 5, which shows the locations of the surveyed projects classified by the professional backgrounds of the initiators.

Table 5 Institutional location of project, by main initiators

	Formal schools	NFE insti-tutions	Health insti-tutions	Not insti-tutional-ly based	Not Stated	TOTAL
Teachers	20	5	0	0	0	25 (22%)
Other formal eds	9	5	0	0	1	15 (13%)
Non-formal eds	10	20	0	2	0	32 (28%)
Health workers	15	0	17	3	1	36 (32%)
Others	1	2	0	3	0	6 (5%)
TOTAL	55 (48%)	32 (28%)	17 (15%)	9 (8%)	1 (1%)	114

There are several points to notice from the table:

a) *The extent to which the formal school is penetrated by project initiators from other institutions.* Of the 55 projects which are located in formal schools, only 20, or 36%, were initiated internally by the teachers working in those schools. The other 35, or 64%, were initiated by professionals moving into the schools from other institutions. In nine cases, these professionals were also employed in the formal education system, but in more senior positions than the teachers. They introduced the projects into the schools in fulfilment of official policy. But in the remaining 26 cases, the initiators came from outside the Ministry of Education. Ten worked as non-formal educators of one kind or another, and as many as 15 as health workers.

b) *The low propensity of teachers to initiate projects outside the formal school.* Of the 25 projects initiated by teachers, as many as 20, or 80%, were located in formal schools: nearly always the school where the teacher worked. Health workers present a striking contrast: only 17 of the 36 projects they initiated, or 47%, were situated in health clinics, hospitals or other health-based institutions. Non-formal educators are in an intermediate position: 20 of the 32 projects they initiated, or 62%, were within non-formal educational institutions.

c) *The tendency of health workers to target the formal school.* When health workers move away from health institutions to initiate projects, (which, as we have seen, they do frequently), they nearly always choose to work in formal schools. Not a single one of the 32 projects located in a non-formal education institution is being run by a health worker, as compared with 15 of the 55 projects located in formal schools.

d) *The imperviousness of health institutions to penetration by non-health professionals.* The outward flow of health workers from health institutions to initiate projects in the formal schools is not counterbalanced by an inward flow of other professionals to start projects in the health institutions. Every single one of the 17 projects mounted in a hospital or health clinic was initiated by a doctor or other health worker.

Who Initiates which Projects

Analysis of the projects indicates somewhat predictably that health workers are keener to initiate "outreach" projects and teachers "enquiry projects".

The main explanation is almost certainly that health workers and teachers tend to have different purposes when they initiate projects. The health worker's main concerns are likely to centre around a series of health problems in the community where he works; problems which are likely to have proved intractable to attack through conventional curative procedures.

The incidence of a wide range of preventable illnesses - malaria, tuberculosis, anaemia - may be high, many infants may be dying from diarrhoea, and immunisation programmes may be making slow progress. But the demands of routine curative treatment may mean that the health worker has little time for community health education programmes. Even if time can be found, the health clinic or hospital where he works may not be a really suitable institution for mounting such programmes, because most community members attend only when they are sick and in need of treatment.

In these circumstances, the possibility of working through the local school, and using the pupils as health messengers, is likely to seem attractive. Pupils form a ready-made clientele and a means of establishing communication with a high proportion of households within the community, including households which do not regularly make use of the services of the health clinic or hospital. Besides, he may argue, children can be more efficient change agents than older people because they are more receptive to new ideas and more effective as communicators.

But for an innovative teacher starting a project within the school, the priorities are likely to be rather different. His main concern will probably be to enhance the competence of the pupils in his care, rather than to train them as health messengers or change agents. The fact that he is seeking to innovate means that he is probably dissatisfied with the traditional didactic-receptive approach to pedagogy characteristic of such a high proportion of formal schools. Enquiry-based approaches, with their emphasis on providing children with opportunities to generate some of their own knowledge through observation, investigation and measurement, will probably have much appeal.

It is very likely that he will include an outreach component in his project. As we have seen, teachers in our survey initiated ten projects with an outreach component as against only eight purely enquiry-based projects. But the teacher's main motive will probably be to extend his pupils' learning opportunities even further, so that they learn to cope better with the human world as much as the physical and natural worlds. If in the process pupils can have a beneficial impact on other people so much the better; but he is likely to see this as a bonus rather than the main purpose of the project.

Several respondents to our questionnaire running projects we classified as 'outreach' stressed the cognitive and affective benefits to the participating children, rather than the outreach benefits. They included health workers as well as educators:

> "It is too early to say, but perhaps the children are developing a new self-confidence and worth."
>
> India

> "The pupils show particular interest if the activity sheet deals with a problem they themselves have encountered, such as the sheet on eyes, as the area has a huge problem with river blindness. It is clear too that the pictures on the sheets are appreciated and understood much more than the wording. It is difficult to say how far the activities have actually been carried out by the children. Obviously we hope that some of what they learn in school they will apply in practical situations and also pass on to their younger brothers and sisters, but unfortunately the school system does not encourage such applicative powers ... Last year there was a cholera outbreak in some nearby villages during the holidays. Some students came straight back to the school to collect rehydration salts; others in villages where sugar and salt were available mixed the drink themselves ... However my own opinion is that the main benefit of the Child-to-Child sheets and similar materials is the long-term educational one."
>
> Sierra Leone

> "Children become more cultured: they become aware of a change and a meaning of life."
>
> India

In a very few projects the distinction between the two sets of goals dissolves, and a more complex, higher order purpose emerges which incorporates them both. In essence, these projects aim to change the nature of authority relationships between young people and older people. Through the acquisition of competence, young people are to be enabled to participate as more equal partners in the life of the wider community; and through this participation, their acquisition of competence is to be enhanced:

> "The most important goal of the programme was to make

> parents, educators and authorities understand the capacity of the child to co-operate and work for the well-being of themselves, their families and the community."
>
> Guatemala (Translated from Spanish)

In the last resort, then, the distinction between the two types of Child-to-Child project which we have identified may be a false dichotomy. Effective learning, incorporating enquiry-based approaches, may be a pre-condition for effective outreach; and likewise outreach activities may be essential for the acquisition of some forms of competency. So if an innovative doctor or other health worker seeking to start an outreach project in a school were to meet equally innovative teachers anxious to introduce enquiry-based learning approaches, they should have little difficulty negotiating a common programme suited to both purposes. Unfortunately, however, such happy encounters are not common. The health worker or other project initiator is more likely to find a group of teachers who are wedded to traditional didactic-receptive methods of pedagogy, in which pupil activities play a minimal part. Such teachers are unlikely to adopt the project as their own unless they are given the opportunity to negotiate its content and its processes.

Materials and how they were used

Analysis of use of the Child-to-Child materials indicated more use made of activity sheets than the Child-to-Child book or readers. Little can be read into this evidence. The activity sheets have been around longer, are readily available and are free.

There are very heartening reports that both the activity sheets and the readers have been used just as their initiators had hoped for. The following quotations from the survey responses are likely to bring a warm glow to those who drafted the materials.

Activity Sheets

> "We used the activity sheets as guidelines for preparing our own material for use in the backward tribal areas. The materials on water, sanitation and accidents were most useful because they are simple, easy to understand, and effective."
>
> India

"The activity sheets have been inserted into our monthly magazine, as well as being given to teachers for use as resource teaching materials. 'Accidents' has been much appreciated by the women's groups. 'Our Teeth' is an excellent handout for school children. 'Immunisation' has been used to boost the immunisation programme."

Zimbabwe

"Using the activity sheet 'Our Teeth' the children mimed the story of dental care. Another activity sheet gave us the idea of planting mango seeds. The children took the little trees home to their villages, and now every year seedlings are grown and planted in the villages at the start of the rains."

Senegal (original in French)

Readers and Book

"We used the Child-to-Child readers, translated into the local language, in primary schools located in refugee camps. We found them useful because they provided children with reading practice, and at the same time health education."

Thailand

"The readers are used by the children in both the English language and the health science lessons."

Sierra Leone

"We used the Child-to-Child book and the activity sheets in preparing three low cost story booklets of our own. Mental stimulation and value formation were emphasised. We also made a lot of worksheets for children to practise their skills in counting, letter-identification, colouring etc."

Philippines

However, a breakdown of which activity sheets and readers were actually used and preferred makes far less comforting reading. Some activity sheets *including all those on child stimulation and development* are not mentioned by any project workers, and the same trend is reflected in the sales of the readers. When we analyse the use of the sheets, Diarrhoea heads the list by a wide margin. The reasons are clear: not only is the message a very important one (much emphasised by other health programmes) but it is also simple to comprehend and shows relatively quick and dramatic results. Other sheets such as "Our Neighbourhood" with its emphasis on community health contain much longer term messages and are therefore much less easy to comprehend and act upon, whereas the message that play and child stimulation are important and feasible in every family and social situation, has clearly not got across at all.

The fact that UNICEF stresses child survival (Growth Monitoring; Oral Rehydration; Breast Feeding and Immunisation) far more than it does development may be one reason for this imbalance. Certainly Child-to-Child faces a clear challenge during its next decade to convince its "users" that mental stimulation is an equal partner to preventive and curative health practice.

Use of Materials

As already mentioned, many projects used the Child-to-Child materials either unchanged or with only slight adaptation. But when it came to building upon the materials the evidence is encouraging. Far from the conventional (and quite unacceptable) picture of a teacher or field worker hungry to ingest ready made material, 68% of respondents told us that materials in the projects they had been associated with had been produced locally. The composite of quotations produced on page 43 gives something of the flavour of these adaptations.

Numbers Involved

The survey was hesitant, as we are, in assigning numbers to projects. Many surveyed were very small, a few enourmous. No record exists, or is possible, of children, teachers and health workers who have been affected through reading material which incorporates Child-to-Child messages. We know, for instance, that the government of Tanzania has ordered 32,000 copies each of all six story books so far published. But it will be a long time before we know how many children read them, and we shall never know what they learnt or did not learn as a result of the knowledge they gained.

The total number of children revealed by our survey as being involved in Child-to-Child is impressive, and the true

Table 6 Child-to-Child - How new material were created by local projects

"We made walkers, special tables and play equipment for the rehabilitation of disabled children."	Pakistan
"At Bal Melas (children's festivals) held in various villages we encourage children to sculpt and paint, and then build in stories, poems and songs which they themselves can use to teach and amuse their younger siblings."	India
"A set of posters, 'My Cat and I' concerning personal hygiene."	Mexico
"A large poster praising the children's achievements. It says Child-to-Child across the top. I made a certificate of achievement to give to the headmasters at the schools where the classes were taught and the pupils responded."	Sierra Leone
"We made a set of stories adapted from actual experiences in the village health work."	Zambia
"We held a 100-poster exhibition with simple messages and health diagrams."	India
"We made flannelgraphs and posters on the three groups of food, for use in schools."	Rwanda (original in French)
"We have prepared slides, posters, and audio-visual video films on personal and environmental hygiene, nutrition, and the prevention of dental, eye and ear diseases."	Pakistan
"Songs on the rights of children, and stories written by children about children's issues."	Guatemala (original in Spanish)
"We have published a children's illustrated book, and six issues of the Child-to-Child Newsletter."	Uganda
"We have prepared puppets and cartoons, and have held fancy-dress community campaigns."	Peru (original in Spanish)
"A health education teachers' guidebook, leaflets, flashcards, posters, video films, health education drama, etc."	Nepal
"A set of 12 lessons for teaching in primary schools, mainly in story form and following happenings of a boy and his sister. The stories emphasise learning to care for younger children. We have also prepared flash cards for health education."	Pakistan

number of learners in all Child-to-Child related projects worldwide is, of course, far larger. The materials have to a greater or lesser degree reached many millions of children, but the crucial question still remains not "how many?" but "with what effect?".

Problems and Prospects

Our survey of "Child-to-Child" projects thus gives us at least a partial response to the question "How is Child-to-Child doing?"

Clearly the worldwide interest aroused in the International Year of the Child has not lessened ten years later. The idea retains its force and potential. Many people are trying many different approaches.

Yet equally clearly there has been no sudden worldwide conversion to the concept. The "armies of children" are still waiting to be mobilised behind the idea. We are not surprised. Later in chapters five and six we analyse the real implications of the Child-to-Child concept and uncover what fundamental changes in thought and practice are implied by its acceptance.

In the meantime let us analyse some of the problems raised by those who took part in Child-to-Child projects, a number of which were revealed as relatively short lived.

Problems

A number of respondents expressed concern about the long-term viability of their projects. Shortage of financial and material resources were frequently-mentioned problems (22 and 16 respondents respectively), but even commoner were various worries about how to maintain support for the project, both among participants and among clienteles.

Low levels of morale among teachers, and lack of incentives for them to participate in Child-to-Child activities, were one source of concern:

> "Teachers have low morale due to their low income. Incentives for Child-to-Child are too few, or none at all."
>
> Uganda

Other respondents stressed how difficult it can be to maintain commitment once the initial burst of enthusiasm has subsided:

> "Raising manpower for a specific period is possible. To continue and sustain interest of volunteers is difficult."
>
> India

> "The biggest problem is CONTINUITY. How do we stop a programme fading out?"
>
> India

Problems of continuity are particularly acute in projects which are essentially the brainchild of a single innovator, or of a small group of enthusiasts:

> "Most teachers here will not carry on with the programme now that I am gone."
>
> Sierra Leone

One such project came to an end because the initiating teachers were all transferred to other schools:

> "There was no one following up on the Child-to-Child programme, so when the teachers who had started it left the school, the programme was not maintained. It did not become a part of the curriculum so that it could become permanent because there was no logistic support for it."
>
> Philippines

Even when there is continuity of staffing, there is sometimes a tendency for teachers to continue with traditional methods of instruction, so that the Child-to-Child programme loses its impact on practice, and becomes like any other school subject:

> "Teachers need to be more creative and resourceful. Activities have to be interesting or the children will get bored and the health impact becomes meaningless."
>
> Philippines

> "The main problem is how to move from teaching to practice; to motivate children and adults so that health practices become part of their daily routine."
>
> Angola

For other respondents, the major threat to the viability of the project comes from lack of support from parents and community leaders:

> "Lack of encouragement from parents and from society when need be."
>
> Nigeria

> "The children are very interested to keep healthy and well. But the problem is for the child to convince the parents about disease, dirty water, etc."
>
> Kenya

> "Parents do not understand the need for children's organisations. They even see the activities as contradicting the work of the schools."
>
> Peru

> "Indifference on the part of some leaders in the community."
>
> Philippines

> "The elders at home need to be educated side by side with the children. The children go back to homes where there is no co-operation and they are just left to themselves."
>
> India

> "The most serious problem is how to sensitise adults so that they accept the new ideas which are brought by the children into the family. Some of these families are already habituated in their ways. Adult education to change their ideas is needed."
>
> Togo

The last of these quotations raises a crucial issue: the need for 'triangulated' approaches to outreach in Child-to-Child projects. All the available evidence points to the conclusion that outreach activities are far more likely to have substantial impact if the messages communicated through children are reinforced by direct communication between the project initiators and the parents. A child coming home from school bearing the message that food should be covered against flies or that new foods should be added to the family diet is likely to be received with suspicion, even hostility, if the parents know nothing about Child-to-Child. But if the initiators have already met the parents and explained the project to them, and perhaps taught them some of the material their children will be learning, suspicion is likely to evaporate.

> "The biggest problem is winning the confidence of tribal people. But once they are assured we are not exploiters they learn, react, and reach out for more information."
>
> India

Benefits

In replying to our questionnaire, virtually every respondent who was associated with a Child-to-Child project listed at least one benefit the project had brought about. Many of these replies have already been quoted earlier in this review, particularly in our discussion of differences between outreach and enquiry-based projects. We shall not, of course, repeat them here.

As many as 31 respondents referred to outreach benefits:

> "Polio and measles have been reduced drastically. Awareness has been created among both the older children and their parents."
>
> India

> "Fewer children now die from dehydration. The health science lesson is getting bigger every day and the roll of the school has been increased."
>
> Sierra Leone

'Learning' benefits were mentioned in another large group of replies (13 respondents):

> "Schoolchildren now know the importance of immunisation. They can sing and dance about the six killer diseases, and know stories about malaria and bilharzia."
>
> Zimbabwe

A smaller, but more diverse group of relies referred to various benefits to teaching and learning processes as a consequence of Child-to-Child activities:

> "Medical students have learned to communicate with children the ideas of child health care."
>
> India

> "The integration of the concept of 'well-being' into the science and homecraft lessons has been a benefit."
>
> Zambia

> "Breaking through the barrier of a very traditional teaching approach in the Afghan schools."
>
> Pakistan

Finally, 14 respondents referred to broader, non-specific benefits gained by children through participating in Child-to-Child activities:

> "Perhaps the children are developing a new confidence and self-worth, and others from outside the formal school system are being drawn in."
>
> India

> "Children are aware of their importance in the community as agents of change."
>
> Nigeria

> "The children are encouraged to see and feel that they too play a role in the community."
>
> Fiji

> "Children are more attentive in all activities in the village, the health centre and the school. They have a feeling of their role in the community and a self-worth."
>
> Zambia

The Survey in Perspective

Those who may have hoped that our survey of Child-to-Child worldwide would come up with sets of figures, tables of outcomes and prescriptions for action will have been disappointed by the nature of its findings.

Conventionally projects set objectives and measure outcomes against these. Child-to-Child by its very nature excludes such a strategy. What the survey does reveal, however, is a fascinating and very diverse pattern of activity with many exciting growth points, from which it may be possible to develop real improvements in the quality of education and through it the quality of life. In our next chapter we analyse three such activities in greater detail and in our final two chapters we look in some greater depth at some of the educational directions in which the approaches may point us.

NOTES AND REFERENCES

1. Somerset, H.C.A. *Child-to-Child. A Questionnaire Review and Studies of Projects in Three Countries.* London: Institute of Education, 1988.

2. Werner, D. *Disabled Village Children.* Palo Alto: The Hesperian Foundation, 1987.

3. The remainder of this chapter is taken, in many cases verbatim, from Tony Somerset's report. Some abridgements have been made. The report is available through Child-to-Child, London.

   All quotations are taken from questionnaire responses. Child-to-Child will be pleased to answer queries and supply further information if available and appropriate.

CHAPTER 4

CASE STUDIES

No Child-to-Child programme is the same as any other. In selecting three we are merely seeking to contrast different origins, sizes and purposes. Appendix 1 gives an indication of the *range* of projects which are being or which have been attempted. Yet this is merely indicative. Despite the light shed on activities round the world by our postal survey, information is still fragmentary.

The three programmes selected derive from India (Bombay), and Southern and Central Africa (Botswana and Zambia). The first two are taken from case studies in the Child-to-Child review of 1987. They represent two contrasting but well organised programmes, one initiated by health workers and one by educationists but, significantly, both taking place in schools. The third programme is a national enterprise, very large and very ambitious. Although it started relatively recently, it has been included not only because of its importance, but also because it indicates some of the problems, as well as the advantages of institutionalising Child-to-Child programmes.

Case Study 1 - The Malvani Project, Bombay[1]

The Malvani project grew from an initiative which started in 1976, when the G.S. Seth Medical School and the associated KEM Hospital were allocated the low-income suburb of Malvani, on the outskirts of Bombay, as a field area for the development of methods for the delivery of primary health care and for the training of medical interns and other health workers.

From the earliest days, a major concern of the project team was to develop an effective health education programme for the community, thus reducing the need for curative intervention. Adults, it was found, were willing enough to attend the health centre when they or their children needed treatment for specific conditions, but were reluctant participants in programmes aimed at providing them with the knowledge and skills needed to avoid a recurrence of those conditions. The team's imaginative response to this challenge was to enlist pupils from a nearby primary school as communicators and change agents. Might not children succeed where adult health workers had failed? 'Even an emperor has to bow to the wishes of a child', as one of the key themes of the programme put it.

Judging from the statistics, this approach met initially with a highly enthusiastic response. During the first year (1978-79), as many as 617 child volunteer health workers were trained, who among them brought to the health centre for treatment and advice a total of no fewer than 1331 cases, including 471 cases of scabies, 233 of vitamin deficiency, and 150 of tuberculosis. Over time, there were significant changes in the profile of activities undertaken by the child volunteers, largely as the consequence of earlier successes. Scabies, for example, was widespread in Malvani in 1976, but the low-concentration benzyl benzoate bath treatment introduced at the health centre appears to have been a highly effective control measure. Hence the number of new scabies cases reported by child volunteers dropped from 477 in 1978-79 to only 21 in 1985-86.

As these early activities receded in priority, others, most notably demonstrations of the preparation of the oral rehydration solution, took their place. Introduced in 1982-83, oral rehydration became a central component of the programme, and by 1985-86 was by far the most important single activity, with child volunteers carrying out 289 reported demonstrations, mainly during the monsoon rains when the incidence of diarrhoea is highest.

As happens often with innovative projects, there were difficulties in maintaining momentum once early enthusiasm had worn off. One indicator is the drop in the number of new child volunteers recruited. In 1978-79 there were 617 new volunteers, but by 1982-83 the number was down to 106, and by 1985-86, to only 28.

During a Child-to-Child workshop, held in October 1986 and supported by the Aga Khan foundation,[2] possible reasons for the decline in participation were discussed. It was suggested that for many Malvani children, taking part in a voluntary programme such as Child-to-Child out of school hours conflicted with other priorities: income-generating activities, domestic responsibilities, or school homework. The implementation team therefore decided to take steps to link the project more closely with the work of the schools from which the children come.

Two stages were envisaged. In the first, the main setting for Child-to-Child instruction would move from the health centres into the schools. Doctors and other health workers would strengthen the teaching of primary science by assuming responsibility for appropriate health-related topics. Later, when the class teachers had mastered the new knowledge and skills, they would take over from the health workers as the Child-to-Child instructors.

The current project

The first of these two steps was taken early in 1987. A team of two full-time and five part-time Child-to-Child project officers started visiting two neighbouring primary schools twice each week to work with Standard 6 pupils. The curriculum was organised around a series of projects. By September, the pupils had completed projects on immunisation, vitamin B complex deficiency, and anaemia, and were working on a tuberculosis project. It was planned that by the end of the year, projects on malaria and leprosy would also be completed.

The seven project officers are all health workers, but from varied professional backgrounds. Three are qualified doctors, two are medical social workers, one an occupational therapist, and one a medical statistician. They work with the guidance of the project co-ordinator, a senior faculty member of the G.S. Seth Medical School who has played a major role in establishing both the Malvani Health Centre and the Child-to-Child project.

One of the schools the team works in is a Bombay municipality vernacular-medium school, and the other a private English-medium school. The vernacular-medium school is effectively three schools under one roof. Pupils can choose education through the medium of Hindi, Marathi or Urdu.

Contrary to what might be expected, the municipal school has much the better physical facilities. Classrooms are large and airy, and upper-standard children have desks. The private school, by contrast, consists essentially of one room, divided into teaching areas by flimsy partitions. The roof is of uninsulated metal. Conditions are crowded and noisy at all times, and stiflingly hot during the middle of the day. Most teachers take their classes outside, under trees on vacant land adjoining the school.

The twice-weekly Child-to-Child sessions are usually of two periods each, but sometimes the planned programme cannot be completed in the time available. For this reason, sessions are scheduled whenever possible before the lunch break or at the end of the school day, so that activities can overrun without disrupting the rest of the timetable.

Apart from the class-based programme there are other, less formal Child-to-Child activities which pupils can choose to take part in out of school hours. During the long vacation in July-August, for example, project staff organised no fewer than 13 outings. Pupils visited such places as a tuberculosis centre, a university teaching hospital, a sewage plant, and a leprosy centre. Average attendance was about 50. During term-time, the more enthusiastic participants come to the centre regularly after school hours to rehearse plays, dances and songs on health-related themes for performance on public occasions. Essentially, these activities continue the earlier tradition of Child-to-Child at Malvani.

The thoroughness with which the formal school programme is prepared and carried out is most impressive. The sequence of activities varies with the topic, but the school pupils always play a central role. For example, the anaemia sequence was as follows:

1. Formal teaching of basic anaemia facts. Pupils taught to recognise three clinical signs (1 period).

2. Detection of anaemia within class; paired pupils examine each other (1 period).

3. Haemoglobin tests of pupils showing positive clinical signs (1 period).

4. Treatment of anaemia in pupils with positive haemoglobin tests, plus recapitulation of basic anaemia facts (1 period).

5. Trained pupils conduct anaemia survey of all pupils in school (3 periods).

6. Haemoglobin tests of all school pupils showing positive clinical signs (3 periods; trained pupils brought the pupils they had identified).

7. Treatment of anaemia in all school pupils with positive tests, plus anaemia education for whole school (3 periods).

8. Community survey. Trained pupils, in groups of four, each accompanied by a Primary Health Centre worker, visit six homes (including their own), and examine all household members for anaemia. Those showing positive sign advised to come to the Primary Health Centre for testing (2 visits, 2-3 hours each).

The entire anaemia programme takes six weeks: five weeks in school, and one week carrying out the community survey. The period of time taken for the immunisation programme was about the same; for the vitamin B complex programme rather shorter.

One of the most impressive features of Malvani is the efficiency with which outcome data are collected.

Table 7 sets out the results of the in-school survey on anaemia:

Table 7 Results of Malvani Anaemia Survey

School Language Medium	Child-to-Child Partic.	Pupils examined	Clinical signs	Anaemia confirmed	% confirmed
Marathi	50	730	292	128	18%
Hindi	35	400	138	61	15%
Urdu	40	495	212	104	21%
English	50	190	65	45	24%
TOTAL	175	1815	653	338	19%

The seven Child-to-Child tutors taught 175 Standard 6 pupils to detect three clinical signs of anaemia (colour of finger nails, tongue, and underside of lower eyelid). These pupils then surveyed 1815 other pupils in the schools they attended. They found positive signs in 653 pupils (36% of pupils examined), and 338 of these (19%) were confirmed as anaemia cases by blood test. All the pupils with confirmed anaemia were given treatment. The in-school programme ended with talks to all pupils in which the Child-to-Child tutors explained how appropriate diet could prevent anaemia.

In the community survey, Child-to-Child participants examined 2354 people, and found clinical signs in 634 of them (27%). It is interesting that signs of anaemia were more frequent among school pupils than they were among the community generally.

There can be no doubt at all that the benefits from the Malvani project - both 'learning' and 'outreach' - are substantial. The pupils taking part have learning opportunities which are rarely provided in any school in any country. They have the chance to acquire competence not only through observation and enquiry, but also through application in useful practice. The project's implicit message is that education can be more than just preparation for life in the future; it can also be participation in present life.

An indication of the outreach benefits of the project came early in 1987, when the immunisation campaign for the Standard 6 school pupils was being planned. It was found that virtually all the young children within Malvani had already been immunised as a result of previous Child-to-Child campaigns. In consequence, it was necessary to mount the new campaign in a new area, some distance from Malvani.

The shift in focus of the project away from the health centre towards the schools has, however, created problems. One is the additional workload which has been placed on the health centre staff. Two members of the implementation team were appointed to work with Child-to-Child full-time, but the other five have further duties in the health centre. Their main obligation to Child-to-Child is to run the twice-weekly sessions in the schools, but inevitably they get caught up in a wide variety of other activities, ranging from supervising the children when they are carrying out community surveys to assisting in the preparations for Child-to-Child performances. Such a scale of involvement obviously causes us to question whether a project along these lines would readily be replicated by other bodies.

One way that has been suggested to reduce these burdens somewhat might be to increase the involvement of medical and paramedical interns in Child-to-Child. At the moment interns participate mainly on a voluntary basis, and only in activities which take place at the health centre. They take no part in the school-based programme.

The opportunity to give young people about to enter the health professions experience of working in a health education programme involving both children and the wider community seems one that should not be missed. Such experience might well prove to be a highly effective means of sensitising interns to the importance of preventive approaches to health care.

The establishment of linkages between Child-to-Child and other school programmes is another important issue which has emerged as the focus of activities has moved from the health centre to the schools. So far, little progress has been made. Child-to-Child is still essentially an encapsulated programme, following its own syllabus, employing its own methods, and implemented by outsiders.

Some teachers have shown interest, but most remain onlookers rather than participants. A major reason is that the material the children must learn to take part in the outreach activities takes them well outside the boundaries of the formal school health curriculum and the limits of the teachers' competence. Only one topic covered in the Child-to-Child programme is included in the Standard 6 science textbook. In consequence, most teachers continue to teach the Standard 6 primary science course (which includes a health education component) as if there were no Child-to-Child programme.

This has led to timetabling difficulties. Officially, only three periods each week are allocated to the teaching of science, but the Child-to-Child and science courses take a total of seven periods. It has proved easier to find the extra periods in the two schools where Standard 6 teachers are generalists than it has been in the other two schools where they are subject specialists, because the generalists have been able to adjust their total teaching programme to accommodate Child-to-Child.

The disjunction between the two programmes is not just a matter of content: there are equally sharp differences in pedagogical approach. The six health-related chapters in the Standard 6 textbook are entirely didactic: they list facts for pupils to learn. Not a single activity is suggested through which pupils might establish, or even verify, some of the facts for themselves.

Teachers are reluctant to deviate from the textbook because of pressures on them to prepare pupils for end-of-term and end-of-year examinations. These pressures become more intense in Standard 7, when pupils sit an externally set 'Board' examination. Although promotion from Standard 7 to Standard 8 is nowadays more or less automatic, schools are held accountable for the results they obtain, and it is widely believed that promotion opportunities are contingent upon them.

But even in the lower standards, examinations are important events. To allow pupils time for revision, the Child-to-Child programme stops two weeks before the end-of-the term examination in October, and a month before the end-of-year examination six months later.

It may well be that the gap between Child-to-Child and the school primary science programme is too wide for effective bridging. Certainly a strong case can be made for Child-to-Child retaining its separate identity, especially if the programme becomes a means of providing medical trainees with experiences of activity-based approaches to health education. Clearly, the topics included in the Child-to-Child course are of much relevance to the needs of people living in Malvani. But the character of the primary science course is not something that Malvani teachers can negotiate with the Child-to-Child team. The syllabus, the textbook, and to a large extent the examinations, are prescribed for them at state level; and between them these three have a powerful, perhaps decisive, influence on pedagogy.

There are, however, ways in which linkages could be established. First, and most important, teachers could be provided with the knowledge and skills which would enable them to become participants in Child-to-Child, rather than observers. At the moment, teachers feel vulnerable, because they themselves have not mastered the knowledge and skills the pupils are acquiring. Their natural response is to withdraw, for fear their ignorance may be exposed in front of the pupils. A health education programme designed specially for teachers, which would take them beyond the levels of competence expected of their pupils, could do much to build confidence, and thus provide the essential basis for effective collaboration between health workers and teachers. Unless the teachers can feel that they have real expertise to contribute, they are unlikely to start feeling that they too have a stake in Child-to-Child.

Second, there is scope for adjusting the content of the Child-to-Child programme so that the topics chosen are a compromise between the priorities of the health centre for extension work and the requirements of the primary science syllabus. At present, health centre priorities seem to be paramount. Topics covered in the Standard 5 and Standard 7 textbooks could of course be included, as well as those in the Standard 6 book.

Finally, there is also the possibility that an initiative from Malvani could, in the medium or long-term, help bring about changes in the science textbooks. The 1985 National Policy on Education stresses the importance of child-centred and activity-based approaches to learning, and also the need to relate science to aspects of daily life, including health.

New curriculum materials are already being produced at the National Council for Educational Research and Training (NCERT) in response to these guidelines. No doubt when these are published, state departments of education will begin planning to replace their own materials, and will be seeking ideas as to what changes are needed.

Case Study 2 - The Botswana Child-to-Child Programme[3]

Child-to-Child in Botswana has a dual purpose which is perhaps unique. The aim is to provide, in a single programme, informal preschool education for young children, and enrichment of the educational experience of older, primary-level children. The older children (known as 'little teachers') help prepare the younger children (the 'preschoolers') for school entry, and by so doing, enhance their own cognitive and affective growth. In schools where the programme is well established, many pupils benefit from Child-to-Child twice: first as preschoolers, and later as little teachers.[4]

The programme started in 1979, during the International Year of the Child, in two pilot schools. Since then the number of participating schools has increased steadily, and today (1987) stands at 28. There is little doubt that expansion would have been more rapid if financial and organisational constraints had not been so severe. Interest in Child-to-Child from both parents and teachers has been consistently high, and many schools wanting to join the programme have been forced to wait.

Initially, members of the American Women's Association (AWA) took a major part in designing and implementing the Child-to-Child programme. They worked on a voluntary, part-time basis.

Gradually, however, the AWA withdrew from active participation, and the programme is now managed by a full-time team of three.

Formal control of the programme is vested in the Board of the Child-to-Child Foundation of Botswana. The Board includes representatives from the Ministry of Education, the Ministry of Local Government and Lands, multilateral and bilateral aid donors, and the American Women's Association. The Honorary President is Mrs Gladys Masire, the First Lady; and the President is Lady Ruth Khama.

The Original Child-to-Child Scheme

As nearly always happens with innovatory programmes, Child-to-Child in Botswana has changed in many ways, some major and some minor, since it was first established. The most important change has been a shift in emphasis from out-of-school to in-school activities. We shall start with an account of the original scheme, and then move on to a more extended discussion of the programme as it functions at present.

The initial conception was that Child-to-Child would function mainly as an outreach programme. Child-to-Child teachers would instruct pupils, who would in turn carry the messages to younger children who had not yet started school, in cascade fashion. The transmission of knowledge and skills between the classroom teacher and the little teachers was to be largely separated, both spatially and temporally, from the transmission between the little teachers and the preschoolers. This original scheme was rapidly modified: by 1981, preschool pupils were attending school regularly, and taking part in activities supervised by Child-to-Child teachers.

Initially, a rather tightly-structured programme was envisaged. The older children - the little teachers - were to be drawn from Standard 1, the intake class. Each little teacher was to choose a younger child - a sibling, relative or neighbour - who was due to start school in the following year. The little teachers were to receive two additional periods of instruction from the Child-to-Child teachers each week, at the end of the normal school day. The little teachers were then to return home, and teach the younger children (the preschoolers) the knowledge and skills they had acquired.

To guide Child-to-Child teachers, two booklets containing detailed lesson plans were developed. These booklets are still in use, despite the changes in the pattern of Child-to-Child activities which have taken place in the meantime. Each contains 16 lessons, to be covered in eight weeks. The lessons are grouped into four units, each of which focuses on a general theme. One or two specific topics are listed for discussion each week.

Themes and topics are as follows:

Book 1	Unit 1	Introductory sequence
	1.	Who am I?
	2.	Who do I live with?
	3.	Feelings
	4.	Feelings and needs
	Unit 2	Preparing for school
	5.	Getting ready for school in the morning; road safety
	6.	Routines of the school day Recognition of the four basic colours
	7.	Greeting people at school Shyness
	8.	Things we need to go to school (includes immunisation) Prevention of infection at school
Book 2	Unit 1	Health in the home
	1.	Safety at home
	2.	What makes us healthy? Cleanliness Good food and water Immunisation Treatment for disease
	3.	Nutrition: the three major food groups Growing food Energy food Protection food

Unit 2 The Village

4. The people that work in the village and how they help us
5. How we can help the people in our village
   Rules: at home, at school, in the village
6. Domestic animals, and their productive uses
7. The lands, and their economic significance
8. Crops, and their productive uses

The lesson plans for each topic follow a standard format. They are structured and fairly prescriptive. Each sequence starts with a statement of aims, followed by a list of objectives, usually phrased in behavioural terms ('The child will be able ...'). Next comes a list of equipment and materials. The lesson outline, broken down into a sequence of steps, then follows. Typically, the first step is a feedback session: the little teachers are asked to report on their experiences in teaching the material of the previous lesson to the preschoolers. In the final step, the little teachers are usually prepared for the work they will carry out with the preschoolers before the next lesson.

Paradoxically, this early scheme provided the adult classroom teachers with more guidance in methodology than it provided the little teachers. The lesson plans for the Child-to-Child teacher set out a sequence of activities for instructing the little teachers in considerable detail. The methods suggested combined receptive learning with activity-based approaches: essentially the methods taught in Botswana primary teachers' colleges, and practised in many of the better infant classrooms. It seems likely, then, that for many teachers Child-to-Child approaches to instruction were already familiar - although of course much of the content of the programme will have been novel. They may thus have been able to become Child-to-Child teachers without having to modify their teaching styles a great deal.

The little teachers, by contrast, were left largely to develop their own methods. It seems to have been assumed that in the informal and 'natural' environment of the home or the neighbourhood, effective transmission would take place spontaneously, provided that the little teacher understood the material well. Hence most of the effort of the Child-to-Child teachers was directed towards developing the little teachers' mastery of content, rather than developing skills.

The Move Towards School-based Activities for the Preschoolers

The most important change to the original Child-to-Child scheme has been the introduction of regular in-school sessions for the preschoolers. This change started early, and was already well established by 1981. Typically, preschoolers now come to school twice each week to take part in Child-to-Child sessions. There are, however, important differences among schools in the way in which this change has been accommodated, and in the extent to which home-based activities have been retained. In his survey report, Tony Somerset records the following impression of the activities observed:

> "In one of the schools visited, the work of the little teachers is now divided approximately equally between school and home. Child-to-Child teachers hold a training session for the little teachers before each visit by the preschoolers. During the visits, little teachers work with the preschoolers in pairs, using materials they have prepared during the training sessions. Child-to-Child teachers are present during the in-school sessions for the preschoolers, but their role is mainly organisational and supportive. Most instruction is left to the little teachers. It is noteworthy, though, that for much of the time the little teachers and preschoolers work together collaboratively, on common tasks. On the day of our visit, for example, the pairs of children had just finished drawing pictures of themselves, on the same sheet of paper. Each child had indicated who he was by writing his name under his self-portrait. Some pairs had made their pictures into a joint effort by adding houses, animals or other people to their self-portraits.
>
> After the in-school sessions, the pairs continue working together at home. Apparently much of this work is fairly formal: the preschooler practises writing letters and numbers, learning simple number bonds etc. Sometimes the little teacher uses a worksheet he has prepared during the training sessions, but often the children write in the sand, using a finger as a writing instrument. The little

teacher has an opportunity to report on his experience during these home lessons in the next training session with the Child-to-Child teachers.

In this school the demand for an in-school programme for the preschoolers has been met, but at the same time the original programme for the little teachers has been maintained. In some of the other schools visited, by contrast, preliminary training sessions for the little teachers have been largely or wholly abandoned. There is only one main type of Child-to-Child session, and little teachers and preschoolers attend it jointly.

Teachers have developed various strategies for coping with the twin clienteles. A common approach is to spend part of the session working with all the children, little teachers and preschoolers, in group activities; and then for the rest of the time to split the children up into the Child-to-Child pairs.

Teachers vary a good deal in the relative emphasis they give to group and to paired activities. In one classroom, teacher-directed group activities were used mainly to prepare children for their work in pairs. In another, by contrast, teacher-directed activities continued through most of the session, with the consequence that the role of the little teachers was scarcely different from that of the preschoolers.

It is noticeable, however, that even in those classrooms where the children spend most of the session working together in pairs, the little teachers seem less confident, and perhaps less effective, than they are in schools where they still receive specific preparatory training. They supervise the work of the preschoolers quite well, but most of the actual instruction tends to be left to the adult teachers.

There is also variation in the degree to which an outreach element has been retained. In one school, Child-to-Child is now entirely school-based. All activities take place on the school premises, and furthermore, Child-to-Child has now entered the regular teaching programme and appears in the school timetable. In the other schools, Child-to-

> Child is still an extra-curricular activity, scheduled outside of regular teaching hours, but home-based instruction seems to be an important component of the programme in only two."

Several factors are likely to have contributed to this shift in focus for Child-to-Child activities away from the home and into the school. Child-to-Child teachers may have felt that the original scheme did not provide them with enough opportunity to supervise the work of the little teachers. Furthermore, the organisation of home-based programmes is likely to have posed problems which could be avoided by moving the activities to the school. What arrangements, for example, should be made for a little teacher who does not have a younger sibling, relative or neighbour of suitable age living near his home? When the little teacher returns from school, does he have enough free time, and can be find a suitable place, to carry out his programme with the preschooler?

But in all probability, parental demand for institutionalised preschool education has been the most important force promoting the shift in focus. In Botswana, as in many other developing countries, public estimation of the value of preschool education has risen steadily over recent years. As competition for entry to the better-rewarded opportunities in formal employment has intensified, so parents have sought to provide their children with education of a kind that will enhance their achievements, and so improve their chances of success. It is widely believed, probably with good reason, that children who start their education early, before the normal school entry age, have an invaluable headstart in this competition.

Only one of the six schools visited had been running Child-to-Child long enough for the first group of preschoolers to have completed their primary education. In this school, results in the Primary School Leaving Examination (PSLE) showed a sharp improvement in 1986 - the first year that there had been ex-preschoolers among the candidates. Both the headmistress and the chairman of the Parent Teachers Association were convinced that the Child-to-Child programme had been responsible for this improvement.

Other Changes in the Original Scheme

A switch in emphasis from home-based to school-based activities is by no means the only change which has occurred in the Botswana Child-to-Child programme since its inception. There have been changes to suit different patterns in population movement - with special variations in schools where there is a high proportion of children whose families travel seasonally to cattle posts.

There have been changes to instructional approaches with a variety of patterns of partnership developing between the class teacher and the "little teachers".

There have been changes in the pattern of selection of both the preschoolers and the "little teachers". Schools vary widely in the ages at which they admit pre-schoolers (and the length of time they attend) as well as the ages and grades of the "little teachers". In some schools these are standard I children, in others standard II and III children are used, and in some all three.

All these variations betoken a living, growing programme which accommodates modification by those who operate it.

The Future of Child-to-Child in Botswana

There seems little doubt about the benefits which Child-to-Child conveys to schools in Botswana which participate in it. The exact nature of the gains may be difficult to quantify but few who have participated in or observed the programme would doubt that they are substantial.

However the future of the programme is still not fully assured: dependent as it has been on external funding it must still seek to be fully and reliably financed from sources within Botswana. Until this is done and until Child-to-Child is very closely linked within a national pattern of other institutions working within the field of early childhood education, especially the Ministry of Local Government and Lands, the Ministry of Education and UNICEF, its continuation cannot be counted as certain.

Case Study 3 - Child-to-Child in Zambia[5]

Under the presidency of James Grant, the "Child Survival and Development Revolution" has been the central priority of UNICEF's policy and in many countries the Child-to-Child approach has been seen by groups and individuals, as well as by UNICEF itself as a very effective means of helping to accomplish such a revolution. Zambia provides an interesting example of a country which has followed this line.

As in many other countries, a number of separate Child-to-Child initiatives followed the International Year of the Child, and these waxed and waned depending on the commitment and continuity of those who initiated them. By 1985 it seemed, certainly from the information available in London, that the two most important programmes were that based in the Northern Province at the Centre for Christian Leadership in Mpika, which since 1984 had run courses in Child-to-Child for over 2,000 teachers, and that in Lusaka Province organised by a team headed by the Provincial Medical Officer.

Both programmes work in schools and with teachers (though outside the formal curriculum). Both were closely committed to the UNICEF message, though they had wider aims, as the following statement of objectives from the Lusaka project indicates.

> "Teachers will have the following responsibilities in the programme:
>
> i. To select suitable pupils who should participate fully in the programme. Pupils should preferably be sixth graders.
>
> ii. To motivate and encourage school children to participate fully in the programme.
>
> iii. To try and involve the local community in health programmes.
>
> iv. To suggest to school children new health activities to be undertaken at each particular school.
>
> v. To create awareness among school children of the existing health problems and possibly find solutions to them.
>
> vi. To promote healthy living habits among children."

One central feature of both programmes was their use of children to collect and spread information within their communities. Children went into their communities accompanied by their teachers and with the knowledge and support of the local community leaders. Surveys in the Northern Province concentrated initially on Nutrition, those in Lusaka on Oral Rehydration.

Information gained was clearly welcomed by the provincial health workers. It presented a useful local sample of conditions and attitudes to health priorities. But even more important seemed to be the interest and enthusiasm raised in both teachers and pupils. In both programmes reports were extremely positive. A feeling of commitment and involvement had been engendered. It is difficult to say from the enthusiastic reports received (both written and oral) whether such interventions had any contrary effects. None were claimed, but there are clearly dangers in the use of children in this way. There were reports, for instance, that one school-based team identified the child of the health worker as being malnourished. His reaction was said to have been one of concern, but one suspects that he would hardly have been pleased.

A National Seminar

As a result of correspondence with Child-to-Child London a national seminar was convened in July 1986 (partly funded by Child-to-Child) in order to share information about national programmes, to offer opportunities for Zambians to dip into the "international bag of ideas" and to discuss the future potential of Child-to-Child approaches. The seminar was originally conceived with rather modest objectives though, as usual, wide representation was planned to include, in addition to those who were organising current programmes, participants from different interest groups in the Ministries of Health and Education and from the University of Zambia's Faculty of Medicine.

But the profile and expectations of the seminar were transformed by the decision of President Kaunda to accept an invitation to open it and by his obvious personal commitment to the idea.

He ended his speech with the following call: "I want to see it in every school in the Republic: teachers, health workers, agricultural workers, church personnel, all helping each other to help children to help themselves."

With such an innauguration it was hardly surprising that the seminar was both dynamic and productive. Working groups considered various aspects of possible Child-to-Child action, widening it out from the original emphasis on Child Survival priorities to other key areas such as community hygiene, recognition and understanding of handicapped children and child stimulation and development. At a final session of the seminar each participating agency - the Ministry of Education (Inspectorate and Curriculum Centre), the Ministry of Health, the University and the Churches - gave an indication of how they would be prepared to help within an informal network of action. The Provincial Health Education officer for Lusaka, one of the initiators of the current projects, was chosen as the co-ordinator of such a network.

But the President's intervention had fundamentally altered the nature of Child-to-Child. It had now become transformed from an association of related local initiatives, governmental and non-governmental, to a national programme co-ordinated at Lusaka. National programmes, by their very nature have to have an infrastructure and a bureaucracy capable of spreading all round the country. National programmes have to have a single institutional base, a timetable for action and a budget. All these Child-to-Child Zambia acquired, together with the offer of very generous support from UNICEF to provide transport and training facilities. A Child-to-Child Executive Committee was nominated, with a Senior Inspector from the Ministry of Education as its chairman, to serve as the base of the programme. The committee was widely representative, but several names were absent from it, including that of the former co-ordinating chairperson from the Ministry of Health, her omission being justified on the grounds that as a medical officer she had no direct responsibility for health education.

A very ambitious programme was planned. Provincial and district committees were set up, some training provided and some training materials generated. Reports delivered at a further seminar in January 1988 jointly supported by UNICEF and Child-to-Child, indicate that though activity is uneven, there is much evidence of enthusiasm and of a good deal of very diverse action.

The scope of Child-to-Child in Zambia is now much more varied. In one province or another activities have been organised in all the main areas of concern identified by Child-to-Child: community hygiene, safety, helping the handicapped, and child development as well as nutrition and the prevention and management of disease. Only in the Northern Province, however, at the Centre for Christian Leadership are all these programmes taught together.

Moreover some new ideas and directions have emerged. One is the link between Child-to-Child and appropriate technology programmes. In one province activities on nutrition are linked with the making of low cost food driers and food storage containers, and in another activities for the handicapped are linked with the making of appropriate aids.

Other connections are being formed: in one province with a project on water resources, in another with the Ministry of Agriculture programmes, in a third with the Young Pioneers - the youth wing of the ruling Congress Party - and in a fourth with a camp for Mozambique refugees. In every case the health programme is widened and strengthened.

Finally, there are welcome instances of new initiatives towards dissemination. In one province resource teachers have been identified and trained, each working with a group of schools and alongside local health workers; in another, retired teachers and education workers have been identified to spread the messages; and in some areas, as yet far too few, local committees have been set up at school level involving teachers, pupils and in one instance parents.[6]

Gains and Losses

There were thus many gains to be counted when Child-to-Child in Zambia expanded nationwide. Yet there were also a number of losses, at least in the early stages.

Because the programme was a national one, individual initiatives were not always actively encouraged from localities and schools. There were even reports that in some provinces they were discouraged in order that the national programme could proceed at an even pace.

Because the programme was centred at the Ministry of Education, some members of the Ministry of Health who had initially been very active in partnership with the schools withdrew to a supportive, and far more passive role.

Because the programme had been announced as about to take off on a large scale and because, for want of money and expertise, it had not been able to spread as far and as fast as had originally been intended, a familiar gap began to be apparent between expectation and reality, a gap which had never existed when programmes started small and built upon success. Some chairmen of provincial committees reported in January 1988 that in the previous year, faced with a familiar combination of lack of money and lack of information, they had adopted the equally familiar civil servant's response. They had taken no initiative for which they could subsequently be blamed.

Finally, because the programme was "Government", voluntary agencies may have felt themselves somewhat apart from it, although at least one was represented on the national committee.

None of these problems is insoluble. Attempts are even now being made to restore to Child-to-Child in Zambia the spirit of enterprise, enthusiasm and local initiative which characterised its first programmes. A new statement of the purpose of the programme is being drawn up. The national committee representation is being widened, and it is now being made very clear that local contributions and local initiatives, especially from voluntary agencies and from community groups, are greatly valued.

The plain fact is that there is seldom need for competition between governments and local individuals in promoting 'child power' in health education. There is room for any number of complementary efforts to promote better health practices. Each time a success is scored, each time a new idea is accepted and a new practice adopted, it gives somebody else something to build upon.

One further priority is now recognised in the Child-to-Child programme in Zambia - that is to build closer links with teachers' colleges, hitherto much neglected, and a further national seminar has been planned to achieve this. However, the mere fact of holding such a seminar will not in itself be enough; what will be crucial are the approaches and attitudes it promotes. The government chain from director to teacher is a long one. It is only too easy for a wide and generous concept such as Child-to-Child to be narrowed and hardened as it filters down through the system so that the initial concept of child power, child initiative, child enquiry becomes transformed in the hands of the teacher to old, rigid, unchallenging approaches to personal and school cleanliness and the learning of undigested health facts. It is this ossification which a large, centralised programme such as that in Zambia needs always to guard against.

Summary

These three case studies have, each in their own way, illustrated the strength and potential of the Child-to-Child approach and the problems which can beset it. In particular we have seen the interplay between different interest groups and noted how difficult yet how important it is to reconcile them. We have also learnt more about the idea of Child-to-Child. It is revealed as capable of many applications and interpretations, not all of them entirely acceptable to every group.

In our next two chapters we examine the true implications of the idea, and in doing so, discover that the deeper we probe the concept "Child-to-Child" the more disturbing are the implications for those in education and health who would like to conserve present practices and standards. For, if taken seriously, the application of Child-to-Child principles, particularly in schools, can constitute a revolution in disguise.

NOTES AND REFERENCES

1. This case study is taken, with slight abridgements, from the 1987 survey report available from Child-to-Child.

   For further information contact Dr V.R. Bhalerao, Professor and Head of Preventive Medicine, G.S. Seth Medical College, Parel, Bombay 400012, India.

2. The Aga Khan Foundation has supported the project (together with five other Child-to-Child projects in India) and continues to do so.

3. Also taken from the survey report - with considerable abridgement. The quotation on pp. 63-65 is from pp. 88-90 of the report, which also considers other related initiatives in Botswana.

   For further information contact Mrs L. Masalotate, Child-to-Child Foundation, PO Box 0084, Gaborone, Botswana.

4. Use of the term 'little teacher' and 'preschooler' is a recent innovation. Originally the little teachers were simply called 'children'; and the preschoolers, rather ambiguously, 'students'.

5. This case study is not included in the survey report. It derives from four visits made by Hugh Hawes to Zambia in connection with seminars and their preparation, 1986-88.

For further information contact Mr Mambo Mwenda, Director, National Committee on Child-to-Child, Ministry of General Education and Culture, P.O. Box 500093, Lusaka, Zambia.

6. At the national seminar held in January 1988 a group was set up to produce a guide to the organisation of Child-to-Child at school level. This may have application outside Zambia.

CHAPTER 5

CHILD-TO-CHILD IN SCHOOLS - A REVOLUTION IN DISGUISE

Key Concepts in Lifelong Education

Before examining the potential implications of a Child-to-Child approach on systems of education it is worth reminding ourselves very briefly of the nature of Lifelong Education, as defined first in the Faure report "Learning to Be" in 1972[1] and subsequently elaborated in an immense, diffuse, yet often influential literature including many books published by the Unesco Institute for Education[2].

Although it is possible to identify a considerable number of separate sub-concepts which together make up the idea "lifelong education", there are a few which appear particularly central to the idea. These include

i. The concept of *horizontal integration* of learning experiences, one mode of learning complementing another; together with ...

ii. that of *vertical articulation* of such experiences over the lifetime of a learner from childhood to maturity and beyond.

iii. The principle of *flexibility* as to where and when learning can take place.

iv. The *re-examination of the role of the school* as just one agent of education among many.

v. The redefinition and *broadening* of the terms "learner" and "teacher", "learning" and "teaching".

vi. The concept of a *learning society* in which individuals choose their own paths to learning.

Above and beyond this there is a certain underlying view of humanity based on the respect for the autonomy of individuals (what R.S. Peters refers to as "respect for persons")[3] wherever they live and whatever tasks they perform. The concept of lifelong education is thus underscored by the concept of human rights.

The concept of lifelong education, vague as it may be, has been profoundly important in the development of educational thought over the last one and a half decades. But we would be blind if we ignored that it has also been manipulated to suit social and political ends. This happens particularly whenever the concepts are applied without due respect to the autonomy of individuals and to their freedom to exercise responsible choice of their own paths to learning for the purpose of bettering their own quality of life and that of others.

Thus we encounter vertical and horizontal integration within stratified orders in society, a new role for the school within a set of rigid limits provided by the state and a learning society with certain "no go" areas of learning. When we consider these fundamental concepts, in relation to Child-to-Child, as we shall do now, we should do well to bear in mind the danger of these bogus interpretations of lifelong education.

Child-to-Child in Relation to these Concepts

Let us now take the concepts (in their true form) one by one and examine how far the Child-to-Child approach fits alongside them.

Horizontal Integration

> "Education should be dispensed and acquired through a multiplicity of means"
>
> E. Faure et al. (1972)[4]

What is implied here is that the educational experiences of learners, the knowledge, skills and attitudes they gain, need to be viewed as a whole; not only through considering the total experience provided by the school rather than the separate experience provided through individual subjects, but even more critically through looking at all the educational influences which children experience at particular times in their lives. Education from home, school, media, mosque and market can thus be recognised as all helping to form the child, and ways sought for them to complement and reinforce each other. The Child-to-Child approach, emphasising as it does both home, school and community learning, as well as the development of "health across the curriculum", strongly reinforces such attempts.

Vertical Articulation

> "Each stage of human life involves learning so that optimum growth and a sense of fulfilment for that stage of life are attained. It further attempts to prepare for the next stage(s) and for accomplishing a higher quality of personal, social and professional life."
>
> R H Dave (1973) [5]

The concept stresses the importance of regarding education as a continuum and not a set of separate drawers or boxes. Not only is it important that the stages of school be closely linked (so frequently they are not!) but it is even more important that the transition from home to school education and from school to work education be as smooth as possible. (Currently they are frequently traumatic.)[6]

The Child-to-Child approach is strongly committed to developing such integration. Links with home learning are developed either very consciously, as in Botswana, or through the whole approach in activity sheets such as "playing with younger children", "management of little children's stools" and "understanding children's feelings". As school children become older they are encouraged to begin to undertake the health responsibilities at home and in the community that they will assume as adults.

Flexibility

> "Lifelong education is characterised by its flexibility and diversity in content, learning tools and techniques and time of learning."
>
> R H Dave (1973)[7]

Learning can thus take place in school and out. It does not begin with the morning bell nor finish with the dismissal of class or the end of the school term.

The Child-to-Child approach strongly emphasises such flexibility. Children must, of necessity, learn both to observe and to act throughout their waking hours. When the 'little doctor' in Jakarta records a health hazard in the special record book which he carries so proudly, and when the Nigerian girl guide applies the first aid for burns for which she has earned a special badge, they are both learning and consolidating their learning through action.

A new role for the school

> "Institutions of education like schools ... are, of course, important, but only as one of the agencies for lifelong education. They can no longer enjoy the monopoly for educating the people and can no longer exist in isolation from other educative agencies in the society."
>
> R H Dave (1973)[8]

Within the parameters of lifelong education school is revealed as only one agency, though a vital one. Hence children do not go to school to "get educated" or "finish their education". Instead school is seen particularly as providing certain vital educational inputs that cannot be so effectively provided elsewhere. Such inputs include: coherent frameworks for knowledge, such as fundamentals of science, or civic education; development of learning skills, as in language or mathematics; and, possibly most important of all, development of logical processes of thought and enquiry appropriate to different "areas of experience".

This training of the mind is, however, of very little value for improving the quality of life unless it is related to direct experience and reified and consolidated through action. Schools everywhere are often unable or unwilling to encourage such applications.

What Child-to-Child approaches seek to do is to encourage children to apply such learning immediately to action...and action which is of vital importance in communities. Thus, for instance, the skill of weighing and measuring is applied to weighing "my baby" and measuring its growth; the intellectual process of analysis is applied to analysing the logic of traditional beliefs. Which are sound? Which are dangerous? And why?

New definitions of Teaching and Learning

> "Learning to Learn is not just another slogan. It denotes a specific pedagogic approach that teachers must themselves master..."
>
> E. Faure et al. (1972)[9]

A redefinition of the school leads to a redefinition of the role of learners and teachers and to the concept of a learning society. A teacher needs to be conceived not as an individual with a framed certificate but as one who teaches (or more properly, one who *helps learners learn)* through precept, demonstration or example. Likewise a learner is not one who sits at a desk with inky fingers but one who learns from a teacher, from peers, from written resources, from the environment.

Thus the persons of teachers and learners are interchangeable. A teacher becomes a learner and a learner a teacher many times a day.

Such a redefinition of roles is at the heart of Child-to-Child, both as it applies to health education and as it broadens out to other areas.

Children teach others: younger children, peers, even adults. They learn from their teachers, from other children and from many other different "teachers" within the community: the health worker, the healer, the farmer. At the same time a group dimension of teaching and learning is explored. Often a group can teach and learn better than the individuals who constitute it. The participation in plays, games, community health investigations or campaigns becomes a learning experience which individual instruction could not supply.

> "Local and national communities are in themselves eminently educative institutions. As Plutarch said, 'the city is the best teacher'."
>
> E. Faure et al. (1972)[10]

> "For the first time in history, education is now engaged in preparing men for a type of society which does not yet exist."
>
> E. Faure et al. (1972)[11]

The concept of a learning society is a complex one. At the first level it refers simply to the necessity for individuals to profit from all the learning experiences around them and for society consciously to provide such experiences. But it goes considerably deeper than this, to the ability to respond to the demands of change from "the society which does not yet exist". This is what the authors of the Club of Rome's *No Limits to Learning* describe as "an approach, both to knowledge and to life that emphasises human initiative. It encompasses the acquisition and practice of new methodologies, new skills, new attitudes and new values necessary to live in a world of change. Learning is the process of preparing to deal with new situations."[12]

The notion of a "learning society" and indeed the whole thrust of the report *Learning to Be* has considerable political overtones. It invites "conscientisation" at both school and adult level. "Taking charge of one's own life" involves questioning one's own status and questioning the motives of those who may be making one's own life difficult to bear. That is why a good deal of the literature concerned with primary health care is both critical and angry in its analysis of present conditions and approaches.

The Child-to-Child approach strongly reinforces these twin concepts. Learners are constantly urged to "learn from the city", to find out what present realities are, to consider solutions, to use the power of the group to collect and consider such solutions, and to evaluate efforts by finding out "how well we are doing". There are those who have misgivings about the realities which will be so revealed. Should young children be encouraged to uncover problems of malnutrition or pollution or ignorance in their families and communities? It is perhaps safer and less contentious to concentrate on hygiene inspections and "how my body works". Inevitably such questions are asked, and the debate which ensues seldom proves easy to resolve.

Education to Liberate and Control - Alternative Applications of Child-to-Child

Finally we have to ask whether Child-to-Child can be misused, whether in the name of good education the power of some children (supported by the natural conservatism of the preadolescent) is being used to indoctrinate others.

Tragically we have recently been given much evidence that child soldiers can be turned into highly efficient killers. Are children in the name of Child-to-Child being taught to socialise others into patterns of life and belief which most civilised men and women would find unacceptable? In short, are children teaching others

- to accept discrimination
- to hate others
- to foster bigotry in the name of patriotism?

Almost certainly this is so. Child-to-Child is a very effective approach, and the more effective an approach is, the more power it has to indoctrinate as well as educate.

There are, however, two points of reassurance. In the first place a good number of the Child-to-Child messages are non-political. If a child is saved from death by dehydration, measles or burning, as a result of knowledge gained through a Child-to-Child programme, that child's life remains of equal value irrespective of the social or political system into which he or she grows up.

In the second place good education, even if accompanied by indoctrination, has a positive residue. If a child is taught to observe, reason and question, that child will bring these skills into adulthood. Adults with such qualities prove difficult to push around.

Child-to-Child: Implications of the Approach for Schools

It is apparent therefore that the approaches to Child-to-Child are largely congruent with the principles identified by Unesco in 1972 and subsequently as desirable in lifelong education. The fact that both the concept of lifelong education and Child-to-Child approaches can be perverted to achieve results far from those originally intended needs to be recognised but in no way vitiates their desirability.

Of course at the level of rhetoric, no-one is "against" Child-to-Child, just as no-one is "against" lifelong learning. The Child-to-Child logo with its dancing children, the reassuring picture of one child on the back of another, the group of uniformed and well scrubbed school children performing a song about immunisation ... everyone is "for" these.

But once we scratch at the concept a little we discover how revolutionary it is, how basically threatening to current objectives, plans, structures, organisation and methodology in primary schools, as well as to the professional status of the teachers employed in them. Let us take these categories one by one.

Aims and Objectives in Schools

Conventionally education defers its objectives. We learn something. We are tested upon it at the end of a term or a year. We pass or fail such tests.

Objectives are to a greater or lesser extent determined by the real needs of children. The best education carefully links objectives with needs but tends almost invariably to concentrate on the needs which children will experience at the end of the school cycle - in other words "needs later" rather than "needs now".

The Child-to-Child approach refocuses objectives to include "needs now". We teach children to learn ideas and skills which they may apply *now, at home, this evening.*

Such a refocusing has profound implications for the status and purpose of testing, since not only does it link knowledge with doing but doing with "wanting to do". It forces us to contrast, for instance, the educational worth of a child who can readily answer a multiple choice test on child development but ignores her baby sister, with another who has developed a real desire to play creatively with a younger child and has the skills to do so.

The Child-to-Child approach also causes us to reflect on the status of objectives. Most teachers' colleges and curriculum development centres now encourage the framing of objectives in behavioural terms and these are then stated in the syllabus or the scheme of work or the lesson plan or the textbook thus:

> "By the end of the lesson the learners will write correctly six signs of dehydration; mix a special "rehydration" drink with correct proportions of water, salt and sugar and taste it."

Very correctly put!

But what if during a survey of attitudes to oral rehydration, children have discovered that parents are quite unwilling to give such a special drink because traditional treatment of diarrhoea suggests a totally different approach (e.g. turning a child upside down and beating the soles of its feet in order to raise the sunken fontanelle)? In this case, as in many others, a new objective has emerged based on the local knowledge gained by the children themselves. Such derived objectives present an uncomfortable alternative to the tried and trusted method of suggesting a whole set of pre-packaged learning outcomes, year by year, term by term, month by month.

Plans and structures

There are equally disturbing implications for those who plan and monitor content in syllabuses and textbooks.

In the first place there are discomforting variations in health needs and priorities from year to year and from place to place. But far more inconvenient to the planner is the whole nature of the subject and the Child-to-Child approach.

To the tidy-minded curriculum planner subjects have boundaries and topics have periods. They can all be neatly pidgeonholed. Thus you can assign the topic "accident prevention" to a health education period in year 3 term 2 week 4.

The Child-to-Child approach gives the lie to this method of planning. Are we to say that a seven-year-old who sees his nine-month-old brother crawling purposefully towards the cooking pot should not be aware of such accident hazards and should not therefore restrain the baby? Thus the teaching of health at primary school level demands an approach which introduces a large number of fundamental health concepts very early and then "spirals" them to suit the age, interests and experience of the child as well as the needs of families and local communities.

Teaching about health in this way also invites us to look afresh at the whole approach to planning and presenting a school curriculum. Currently we present subject syllabuses neatly correlated with a set of subject periods. The teaching of health fails to fit into this pattern, more especially once the Child-to-Child approach is used.

Instead of a menu of classroom content we need a set of concepts, say safety, personal hygiene, community hygiene, child care, management of disease and so forth, and a set of objectives, i.e. goals of knowledge, skills and attitudes which we could expect most children to have acquired by a particular age. We also require an indication of what we might reasonably expect children to do, have done or be able to do with such knowledge and skills.

Side by side with these concepts and objectives, we then need to consider the opportunities children should be offered to acquire and apply them

- in special "health education periods"
- through the medium of other subjects
- through action, example and responsibilities built into the life of the school
- through planned and informal interaction between children

- through individual and group action in families and communities.

Thus a class syllabus becomes transformed into a school and community health plan, and that plan is linked not to the ground a teacher has covered with a class but to the health experiences gained by individuals. A subject syllabus becomes a school curriculum based round an "area of experience".[13]

How much more educationally valuable!

How much truer to the noble rhetoric of the Faure report!

But how much more difficult to set out, monitor or give marks for!

School and Class Organisation

Child-to-Child poses another set of dilemmas to those who plan school timetables. Once children become engaged in school-based surveys and health campaigns they overrun conventional period times. If children become involved in helping each other across grade levels or become involved, as in Botswana in school-based work with pre-school children, then considerable reorganisation becomes necessary.

Once co-operation is sought with health personnel a considerable amount of flexibility will be necessary from the school. Health workers are not captive and amenable in the same way as teachers are, and it may well be necessary to schedule their inputs when they have the time to make them and not when the timetable dictates.

None of such reorganisation is very difficult - especially in primary schools where one teacher commonly teaches all subjects in the same grade, but to depart from the norm a teacher or a head requires support, particularly from education officers and inspectors at local level. Unless these are in sympathy with the new approaches such support may not be given.

Methodology

It is in approaches to classroom methodology that the deepest and most fundamental challenges may emerge. On the face of it a change from a more didactic approach to one offering children greater "involvement" while learning health education (or anything else for that matter) is both desirable and achievable. Indeed governments and teacher educators all over the world recommend such "student active learning".

But generally it just doesn't happen. Often we are told that the reasons are logistical: teachers with large classes have no alternative but to stand and shout at them. Of course, this is not true, because fifty children sitting on the floor are going to learn much more by helping each other in groups of eight than they will by trying to listen to a teacher whom only half can hear (because there are five other teachers bellowing away to five other similar-sized groups in the same hall!)

The reasons are much more basic. Learning through involvement requires:

- a different style of programming ...less information being offered but more being understood;
- a different style of questioning, with many more open-ended questions, and far more pupil-pupil questions;
- a different pattern of class control, with the teacher far more committed to organising groups to help each other, and less involved in managing the whole teaching-learning process from the front of the classroom; with children sometimes working outside the classroom, often outside the teacher's reach;
- a longer "topic cycle", for instead of a self-contained lesson, children will very frequently be asked to
    i. plan enquiries in advance;
    ii. conduct them out of class;
    iii. discuss them and make deductions in a subsequent lesson;

and consequently *a totally different teacher-pupil relationship* involving a far more democratic approach to learning, often very difficult to accept in a culture where certain autocratic traditions of adult-child interaction prevail.

Child-to-Child Approaches in Action

Faced with the catalogue of difficulties presented in our last three pages we could easily expect that Child-to-Child approaches would find it difficult to take root in formal school systems.

The encouraging fact is that they have made so much headway in so many countries. We *do* find objectives being redefined, plans and structures loosened, health across the curriculum recommended, older children assisting younger, out of class/out of school surveys encouraged, and new "student active" approaches replacing old didactic ones. Of course for every encouraging Child-to-Child approach observed in India, Zambia, Indonesia, Botswana, Uganda or Guatemala there will be hundreds of conventional health sermons and health inspections. But what seems particularly encouraging is the way that health topics, because they are so closely related to everyone's experience and interest, because they are of concern to teachers as parents and community members, and because they are in some way outside traditional subjects in primary school, seem to offer a very promising path towards breaking down "restrictive practices" in classrooms.

Beyond Health Education: The Wider Implications of Child-to-Child in Schools

It is a short and inevitable step from promoting "child power" in health education to considering its application to the school as a whole.

In one respect this step has already been made by Child-to-Child. Once the link has been established between mental and physical health, once it is accepted that teaching a child to play creatively and intelligently lays a foundation for later development and enhances the quality of the individual's life now and later, then the whole approach to teaching young children at pre-school and lower primary levels becomes a field for action.

We immediately ask:

- whether "Botswana style" links between schools and their pre-school communities should not become very common;

- whether older children should not regularly, as they have done in Indonesia, Zambia, Botswana and Bombay, make games, toys and puzzles and apparatus for pre-school or infant classes as part of their craft or productive work lessons;[14]

- whether teaching about child development and the play necessary for mental stimulation of young children should not be included as a compulsory part of courses towards the end of the general education cycle.

Looking further, however, six aspects of Child-to-Child's methodology seem crucially important to the whole approach to primary schools and the quality of the learning they provide. These are:

i. The use of children as educators in classrooms.

ii. The use of "child power" in promoting community awareness, and "community power" to enrich the life of the school.

iii. The use of children's direct experience as a basis for learning - with consequent implications for the design of syllabuses and textbooks.

iv. The acceptance of "needs now" as an equal priority to "needs later".

v. The design of curricula round areas of experience rather than classroom periods.

vi. The design of methods of evaluation so that they pay more attention than hitherto to "doing" and "wanting to do" rather than merely "knowing what" and "knowing how".

Let us take these briefly one by one.

Children as Educators

In the face of promising evidence which suggests not only that children can teach others effectively but that the "teachers" both like it and profit by it, can we continue largely to ignore the possibility of large scale research and action towards using such children power in schools? The compelling equation of rising populations, growing demand for basic education and overburdened economies inevitably points to large primary classes in many countries for many years to come. Action research programmes such as the Impact project in the

Philippines[15], and the Quebec project reported in the 1981 seminar paper optimistically entitled "Teaching Yourself in Primary School" [16], seem to endorse the value of "peer tutoring". But the peer tutoring envisaged in these programmes was often somewhat sterile. Older children were "programmed" to teach specific topics.

Child-to-Child suggests that we may be able to range much wider and more freely in the application of the concept of children working with others in class, across classes, with remedial children and with pre-school children.

Children as Communicators to the Community: Community Members as Teachers of Children

There is already a considerable literature on the community school. We do not wish to add to this - except in relation to two specific points.

The first is that proper community involvement with a school alters the nature of the school programme. A health worker coming into school does not merely come in as an invited guest to "give a talk". She comes in to work with and alongside children towards a worthwhile goal (preventing accidents, increasing immunisation, recognising and combating malnutrition).

Secondly, we need to note that the proper use of children as communicators may influence content selection, for it needs to be harnessed to things that really matter and matter now. It matters *now* that trees are being cut down and the rains are getting less. It matters *now* that there is distrust and violence within communities. It matters *now* that *AIDS* is spreading out of control through many countries in the world.

These are issues in which children power can be exploited and in the process of which their communication skills - in words, music, drama, design - can be effectively used, but as a preliminary such issues need to be recognised and given due priority in school programmes.

The Use of Children's Direct Experience

At a recent workshop in Nyeri, Kenya Child-to-Child examined all the applications of mathematics to health and health to mathematics. They were legion. When we understand number, predict, estimate, measure, or solve problems we may do so in relation to imaginary cases (trains starting from different stations; A, B & C digging holes in the ground), or to real, important issues (population growth; budgets to feed a family; measurement of arm circumferences). In the second case we do much more than teach interesting and relevant content at the same time as teaching learning skills. We also develop and reinforce the concepts and skills far more effectively because they are related to something both children and their teachers understand and value.

The implications for action in both curriculum planning and textbook design as well as for teacher education are clear. Content should no longer be predetermined but, once concepts, processes and skills are identified, every indication and encouragement needs to be given to bodies and individuals at local level - local textbook writers, teachers' groups and centres, and the schools themselves - to devise locally relevant and locally valuable content to exemplify such concepts and develop such skills. It is heartening to find that many primary improvement projects, particularly in India and Indonesia[17], are attempting to do this.

"Needs Now" alongside "Needs Later"

This issue leads us directly into the educational folklore of lesson planning. Commonly lessons are conceived as units. They have an introduction, a presentation, an application and a conclusion all crammed into 35 or 40 minutes.

Real learning doesn't work that way. We learn; we apply. Often we test the validity of what we learn against its application in the real world. What Child-to-Child suggests in health (e.g. learn about accident hazards; go and check if your home is safe; come back and talk about it) is equally valid in practically every other area of the curriculum: language, mathematics, science.

What we very seriously need to develop in primary school is a new approach which decreases emphasis on the single lesson, which enhances the application of concepts to home experience and which tests children on the mastery which they need at their own age and situation rather than what they will need when they leave at the end of their first cycle (as if they all made it that far!)

Currently we tend to use the terms "drop-outs" and "wastage" inter-changeably. With more concern for "needs now", it may be possible to ensure that drop-outs are not wasted.

Curriculum as Areas of Experience

Lessons from the design of curricula in health have direct implications not only for design in such other curriculum areas as language and moral education, but also for the design of programmes for the whole primary cycle and for stages within that cycle - lower, middle and upper.

The time needs to come when countries must review not only the way in which they set out syllabuses but the way in which they write them. Syllabuses need to relate much more closely to competencies acquired than to ground covered and need also to specify *where* learners may be expected to acquire such competencies and demonstrate them - whether in other subjects, in co-curricular activities or through life outside the school.

Assessment

The problems of assessment in health education underline two fundamental concerns. The first of these relates to the difficulties experienced by teachers in classes where children are in sight of a public examination, when it proves exceptionally difficult to raise interest in any 'non examinable' subject. Consequently, though health may remain a concern to all, interest in health education wanes, a problem which can only partially be solved by inserting health-related questions into the 'examinable subjects'.

The second concern is that knowledge and skills must be linked with positive attitudes if they are effectively to transform individuals and communities. Yet attitudes are seldom adequately assessed and still more rarely taken into account when allocating learners to further study or employment.

One reason for this is that attitudes are difficult to measure, but another is that the process of assessment usually requires someone to pass judgement on somebody else (and risk being accused of favouritism or victimisation in the process). Yet such judgements are vitally important, must be made, maintained and, if necessary, reinstated in education systems often too prone to rely solely on the "safe" results of objective tests. Moreover, when Child-to-Child invites learners and their teachers to ask "how are we succeeding", it opens up a new window to assessment. "We" are assessing ourselves rather calling upon others to assess us.

First Steps on the Ladder

This chapter has examined the potential of Child-to-Child approaches in schools, and has shown how such approaches match closely with the principles of lifelong education. We have been somewhat cautious in our assessment of how much can be done and how fast transformations can take place, but remain convinced that health education and the Child-to-child approach offer a very effective vector through which to introduce them.

The strategy, of course, is to see on the one hand the *goals* for transformation and on the other the *steps* necessary to achieve them...the first, second third steps and so on up the ladder.

If our goal is greater and more effective integration of learning areas at primary level, a first step could be to prove that the integration of health concepts with mathematics, language, social studies, moral education is both possible and profitable. A next step could be to apply the same principle to environmental education.

If our identified goal were the use of "child power" across classes we could move easily from the teaching of health concepts to remedial teaching of the basic skills. Table 8 indicates some of the "steps forward" possible in the areas of change examined in this chapter.

Teacher Education

In all this process of transformation teachers are key agents, and the preparation of teachers in colleges and through in-service schemes is a key activity.

Teachers' colleges as institutions are often resistant to change. There are many of us in the Child-to-Child network who would register some concern at rather low levels of activity and awareness by those concerned with teacher preparation. (Why is it, for instance, that in the face of the challenge of large classes, falling standards and shrinking budgets, practically *no* colleges are examining the use of alternative methodologies making more constructive use of interlearning?)

Table 8 Better Primary Education Through the Introduction of Child-to-Child Approaches

Desired direction	A first step towards it based on a Child-to-Child approach to Health Education
1) Towards making much wider use of children to educate each other in schools and outside them.	Giving children particular and designated responsibilities towards the health of their peers and of the younger children in school and at home.
2) Towards (i) Using children as educators in the community	Involving children in an effective and disciplined manner towards gathering health education and spreading health messages
and	and
(ii) Using community teachers as educators for school children.	Making use of health personnel as educators of school children through supervising their activities as well as through direct instruction.
3) Towards (i) Enriching children's learning by linking it with their direct experience	Involving children in understanding, investigating and discussing health problems in their communities
and	and
(ii) Enriching their lives by providing for their current as well as their future needs.	Giving them knowledge and skills they can apply to improving their own health, safety and development as well as that of their families.
4) Towards design of school curricula which develop knowledge, skills and attitudes round "areas of experience" rather than linking all content to subject teaching.	Designing of a "school health plan" which will apply to formal teaching in health and other subjects, to the life of the school and to the activities generated at school but carried out by children at home.
5) Towards designing methods of education which (i) Involve children themselves in the process of evaluating the practical effect of what they have learnt	Encouraging children to keep records of both health actions and effects of such actions
and	and
(ii) Evaluate their attitudes and motivation towards using their learning effectively.	Monitoring children's commitment to spreading good health knowledge and practice and offering positive encouragement to those who have shown themselves so committed.

There is little doubt in our mind, therefore, that teachers' colleges and the teacher educators who staff them constitute a priority target group for Child-to-Child action in the coming years. Such action needs not only to stress the importance of Child-to-Child messages in health education but also to emphasise the wider and deeper implications of the approach to the whole field of primary practice.

NOTES AND REFERENCES

1. International Commission on the Development of Education, president Edgar Faure. *Learning to Be: The World of Education Today and Tomorrow.* Paris: Unesco, 1972.
2. From 1976 the Unesco Institute for Education in Hamburg has published Awareness Lists of documentation on Lifelong Education. Separate bulletins were published between 1976 and 1986.
3. Peters, R.S. *Ethics and Education.* London: Allen and Unwin, 1966, pp. 208-236.
4. Faure, E. et al. *Learning to Be*, p. 185
5. Dave, R.H. *Lifelong Education and School Curriculum.* Hamburg: Unesco Institute for Education, 1973, p. 17.
6. Is this particularly the case where the language of instruction at home and school is different?
7. Dave, op.cit., p. 18.
8. Ibid., p. 16.
9. Faure, E. et al. *Learning to Be.*, p. 209.
10. Ibid., p. 162.
11. Ibid., p. 13
12. Botkin, J.W. *No Limits to Learning. A Report to the Club of Rome.* New York: Pergamon, 1979. p. 8.
13. The concept "Areas of Experience" was first developed in the British Department of Education and Science pamphlet

Curriculum 11-16. London: HMSO, 1977.

14. In two of these instances it was found that the time between examinations and the end of term (when staff were correcting papers) was ideal for this purpose. After some initial guidance older children proved themselves very inventive.

15. Flores, P. *Educational Innovation in the Philippines: A Case Study of Project IMPACT*. Ottawa: International Development Research Centre, 1981.

16. *Teaching Yourself in Primary School*. Ottawa: International Development Research Centre, 1981. See also Cummings, W.K. *Low Cost Primary Education*. Ottawa: International Development Research Centre, 1986.

17. The programmes *Professional Support for Teachers in Primary Schools* (Indonesia) and the *Primary Schools Project* (Andhra Pradesh), both important and active in 1988, are fundamentally committed to greater participation by teachers' groups in the modification of content to suit local needs.

CHAPTER 6

CHILD-TO-CHILD - INTEGRATION OF SCHOOL AND COMMUNITY LEARNING

This chapter, our last, looks at the integration necessary if Child-to-Child approaches are to be seen as an integral part of a learning society. It leads us beyond the school yet looks at the school in partnership with other agencies of learning and development.

School Children - "Under Different Management"

From its inception the focus of Child-to-Child has been upon children of school age. Our last chapter has explored the power of the approach as an element within formal education. We have seen how Child-to-Child approaches in the formal school can break down the fences which school education tends to erect around itself.

But we have also seen, in the previous chapter, how outsiders (often health workers) have used school age children and even the school itself for Child-to-Child activities, what our survey calls "Outreach activities", without becoming fully integrated with its programmes. In Zambia, we can recall, health workers used children and their teachers to undertake surveys, but were not allowed to use official school time to do so. In Bombay in the early stages of the Malvani project children primed by health workers actually took the place of teachers.

There are numerous other instances where school children undertake such Child-to-Child programmes "under different management". A frequent example is through scout and youth groups. The ethos of scouting is very congenial to the Child-to-Child ideal. Children work individually and together in self-help groups. They acquire skills and are rewarded with recognition (badges). It is a short step to build on established skills (some, like first aid, already part of a scout or guide's repertory) to new ones such as oral rehydration, growth monitoring, home nursing and child care. What is clearly desirable is for such out-of-school activities to complement and supplement school ones. What is all too visible is that frequently they do not.

Out-of-School Children

Children of school age are not synonymous with children at school. From the outset Child-to-Child has been deeply concerned with the role of the child minder, almost invariably a girl, often a school drop-out, sometimes withdrawn prematurely from school, sometimes denied the opportunity even to attend. In millions of cases round the world these are the nurses, the surrogate mothers of babies.

In some cases, as in Gujarat, attempts are made to adapt Child-to-Child material and approaches directly to their needs.(1) In others, children at school have been urged to share ideas with them - to help them acquire those basic skills of reading and writing which can raise their morale and status.

There can be no question that this group of children is a prime target for Child-to-Child approaches and that links between this task and the activities planned and provided in the formal school have been consistently neglected.

Second Stage Activities

A further category of Child-to-Child activities revealed in our survey has been those where the materials and approaches were directed at adults: trainee nurses, community health workers, youth on national service or teachers in training.

At first sight these seem to be instances where good material has been identified and is used for purposes other than those for which it was designed. In fact, yet again, we are in the business of reinforcing and deepening attitudes and approaches. If a trainee nurse or teacher understands and applies Child-to-Child approaches (say, making toys, managing nutrition, identifying and understanding disability) and if, at the same time, it is understood that these approaches are also suitable at another level for children to adopt towards each other in school and family, then the approach gains power.

Recently (1987) a Child-to-Child seminar in Uganda considered approaches desirable in teachers' colleges and identified three elements necessary in a "Child-to-Child college":(2)

i. Use of the approaches within the college curriculum and the life and work of the college.

ii. Instruction of students in how such ideas and approaches could be adopted in their practical teaching and subsequently through the new "Science for Health Syllabus".

iii. Identification, assistance and monitoring of certain neighbouring primary schools to be developed as models of Child-to-Child practice.

It is the first of these elements which will determine the success of the other two.

Health and Education - Working or not Working Together

In theory, education and health workers co-operate to enhance the quality of life of children and their communities. In practice they prefer to define their own ideas of operation. Administrative structures, working practices, estimates and budgets all reinforce such separate responsibilities. But the root of the problem is often in individuals' perception of their role.

Health is about stopping people being ill.
Education is about teaching them things.
Health education is about teaching others how to avoid being ill.

Given this simple understanding it is possible to maintain a certain degree of separation of roles. But once definitions are widened:
... once health education is seen to be about mental as well as physical health, child development as well as child survival,
... once the aim of health education as a means of giving learners the autonomy to make sensible decisions about their own health is stressed,
... once the role of health education in development is underlined and the responsibility of children to promote community health as a means of development is realised
... then the notion of separate roles breaks down. Good health and good education are seen as two sides of a coin.

Hence co-operation between education and health needs more than joint planning and goodwill. It needs the development of shared understanding at a quite sophisticated level.

"We Must all Hang Together"

... or else, as Benjamin Franklin said two hundred years ago, "we shall all hang separately".(3) The success of the primary health care message and the Child-to-Child approach to children of school age depends critically upon "hanging together":

- Approaches within the school need to hang together.
- Approaches from health and education need to integrate.
- Approaches to families and communities from the media, from health extension workers, from hospitals and dispensaries need to reinforce and not conflict with each other.
- Finally, approaches from sectors outside health and education such as agriculture and water resources, need to be congruent.

There is a lot of hanging together to do.

One reason such reinforcement is necessary is that the messages being spread through primary health care are often very radical ones. At the first level they may challenge belief:

- on traditional ways of managing and treating disease;
- on traditional practices in nutrition or sanitation.

Such beliefs and practices are only likely to be changed if messages received, discussed and demonstrated are rational, consistent and come from many people who are respected and trusted within a community.

At the second level, and even more fundamentally, messages may be questioning established patterns of authority and control within communities, suggesting a new role for children, for teachers, for families and for community leaders in taking decisions towards their own health and wellbeing.

The fact that many governments are changing their messages and advocating such community autonomy will not have escaped communities - nor will the underlying reason for it: that most governments no longer have the financial power to exercise control over community affairs, even if they would wish to.

Where communities need to be convinced is that if they do take power to intervene to better their own health according to their own abilities, and if they do use children in an effective way to do so, some autonomous authority figure from health or education will not emerge and blame them for taking such an initiative.

Dancing Children and the Democratic Ideal

There will be those who read this book who will have wished we had left the dancing children quietly and happily indoors. It is no accident that so many Child-to-Child projects in our survey were simple and circumscribed (like teaching the rehydration message).

But as we have seen, the momentum of the dance leads us from the shelter of the house into the street outside, and inevitably towards the market place.

Child-to-Child invites us first to reconsider the role of children in school, and thence in home and community:

- from there it is only a few steps... to looking again at what the school is teaching, how children are learning, how teaching and learning prepare children for "needs now" and for an uncertain future...
- a few paces down the street...
  to examining the role of the school and the teachers in it within the development of the community and the present and future role of children in promoting such development...
- round the corner and into the market... and we begin to ask who supports such development and for whom. Will our dancing children be welcomed or feared?

We are in the thick of the market now. There is a policeman with an automatic weapon standing in the corner. Will he join the dance?

NOTES AND REFERENCES

1. Two projects are currently being organised by CHETNA in Ahmedabad, one at Megraj in Rajasthan, another at Mada in

Gujarat. Information on both these projects is available in the Child-to-Child survey.

2. Yiga-Matovu, M. *Awareness Workshop on Child Survival and Development Education.* African Social Studies Programme, Nairobi, June 1987.

3. The remark was made to John Hancock at the Signing of the Declaration of Independence, 4th July, 1776.

Child- to-Child
round the
world
CHILD-to-child Readers
aider
les enfants à
s'entraider—
partout
dans le monde
Kenya
Pakistan
Nepal
Oman
Sudan
Childhood
India
Mexico
Toys for fun
Honduras
Burkina Faso
PRIMARY
HEALTH
EDUCATION
Child-to-Child
round the
world

APPENDIX 1
CHILD-TO-CHILD MATERIALS

Example I

Clean, Safe Water: One of 24 activity sheets produced in English. The sheets are free of copyright and are distributed without charge throughout the developing world. Topics covered by the sheets include: Nutrition, Disability, Stimulation and Development, Prevention and Control of Disease, and Personal and Community Hygiene and Safety.

Example II

As a result of a workshop held in Ahmedabad in 1985, the non-governmental organisation CHETNA has produced several activity sheets including *Malaria*. Some sheets have been adapted to the Indian situation from original material in English: others have been specifically produced in response to local priorities and practices.

Example III

Story Books - English: Two specimen sheets from reading material produced by Child-to-Child illustrate the two levels of language. Six story books have been written by teachers with extensive experience of education in developing countries. Level one books have a vocabulary of 500 words; level two books have a vocabulary of 1,500. Six readers are currently available on topics such as Oral Rehydration, Accidents and Stimulation & Development. A further five are to be published in 1988.

Example IV

Child-to-Child in Other Publications:

i) *Disabled Village Children* by David Werner (California: The Hesperian Foundation, 1987). This book highlights the problems of the disabled child, and one chapter specifically examines the Child-to-Child approach in this area. The same author has also looked at the approach more generally in his book, *Helping Health Workers Learn.*

ii) *Primary Health Education* by Beverly Young and Susan Durston (Harlow: Longman, 1987). Written for teachers and teacher trainers, this book incorporates much of the Child-to-Child material. Several health topics are covered and background information and teaching suggestions are offered.

N.B. This appendix is in no way a comprehensive view of Child-to Child materials. Other publications including curriculum materials, textbooks, handouts, magazines and comics have contained Child-to-Child materials and approaches.

Example I A Child-to-Child Activity Sheet (page 1 of 4)

CHILD-to-child programme

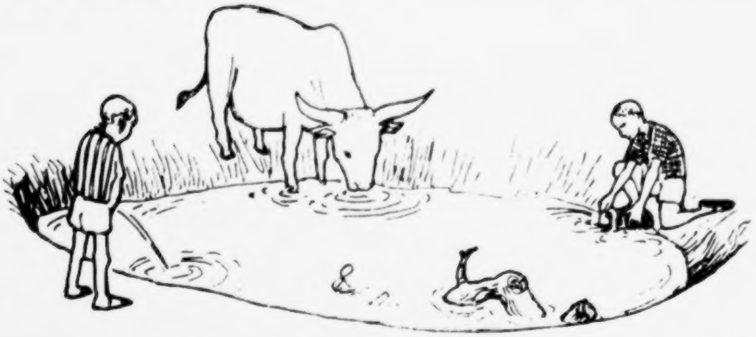
CLEAN, SAFE WATER

THE IDEA

Every living thing needs water. Water is our best friend, without it, animals and humans will become weak and die. In many countries where there is not enough rain, there is not enough water and people suffer. Water is always precious. We must use it carefully and keep it clean. Babies and small children in particular need clean drinking water because they get ill more easily.

BUT

Even when there is water, water can be our worst enemy when it is not clean and safe. Often water has germs in it which can make us ill. Some of the illnesses caused by dirty water are: diarrhoea, dysentery, cholera, typhoid, jaundice and worms. The germs of these illnesses are so small that they cannot be seen and are often in water which looks clean. **THIS WATER IS NOT SAFE.**



These germs get into the water when it is touched by hands, when containers used are not clean, when insects fly over it or on it, or when faeces and urine, especially that of babies, comes near water.

Example I (page 2 of 4)

WHAT YOU NEED TO KNOW

HOW WATER BECOMES DIRTY

WHERE WATER IS FOUND

Springs
Rivers
Ponds
Wells
Water collected from rain
Taps

WHEN IT IS BEING COLLECTED AND CARRIED HOME

The container may be dirty.
Things may fall into the container.
People may touch the water.

WHERE THE WATER IS STORED

Things, flies, dust may fall in.
People may put their hands in it.
People can put dirty cups or ladles in it.

WHEN WATER IS USED

MAKE SURE THE CONTAINER YOU DRINK FROM IS CLEAN

If you are sure the water has been made safe by chemicals you can drink it.
If we are not sure that it is safe it can be filtered by using a special filter, or boiled. Then the water will be safe for drinking.

Always keep drinking water in a well washed container, even if you have boiled or filtered it, and keep a special ladle or dipper to pour the water from the container to the drinking cups.

Do not touch the container or the water you drink.

WHAT YOU CAN DO

NEVER URINATE OR DEFECATE NEAR OR IN WATER

Water belongs to everybody.

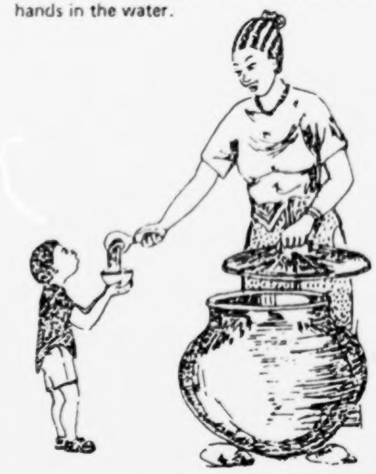
Where there is more than one place to get water, try and keep the cleanest one for drinking water.

In some places, taps and wells may have safe water, use these as much as possible. Don't put a container which has dirt on the outside into a well.

If possible, boil drinking water especially for babies, very young children and sick people.

Always use a clean container for drinking water, clean on the outside and clean on the inside, to collect water.

Always cover the container.
Do not let anything fall in or anyone put hands in the water.



Example I (page 3 of 4)

ACTIVITIES

FIND OUT MORE

At Home:

Make a list of all the containers used for water.
Make a list of people in the family who had an illness which comes from dirty water.
Who collects the water for your home? Try and help them. Who collects the wood to boil the water? Try and help them.

At School:

Make a list of illnesses that can be spread through unsafe water and find out about them.

In the Community:

Make a map of where water comes from and show how it is brought home. How does it get dirty?

TRY AND PASS ON THE MESSAGE: to other children, both school and non-school going children, to parents and family members and to the community.

MESSAGE
- Drama, mime plays
- Song, Dance community singing
- Puppets and demonstrations
- Exhibitions, posters calenders, models
- Stories
- Games

OTHER THINGS CHILDREN COULD DO

1. AT HOME: Make and play pictures, puzzles, and games with your friends and family.

2. AT SCHOOL: Find out what happens at schools. Where does the water come from? Are the toilets near the water course? How often is the container cleaned? Are cups used? Are ladles used? Are cups and ladles washed before and after use? Is there somewhere for children to wash their hands before eating or drinking? If your school has a CHILD-to-child Reader called 'Dirty Water', read it.

3. IN THE COMMUNITY: Play 'Hunt the Rubbish'. Go down to the river and pull out all the old bottles and pieces of rubbish. Dig a hole and put everything into it. Or burn it on a big fire.

HAS IT WORKED?

Is the place where water is collected cleaner? Has all the rubbish been taken away? Are containers always clean, especially on the outside if they are being dipped in the well? Do more children wash their hands after defecating and before eating? How many people are still getting illnesses from unsafe water?

Example I (page 4 of 4)

CLEAN WATER

Some ideas for childrens' activities

STORIES

1. The Children who Grew Small

This story is told in the CHILD-to-child Reader.
A child (or children) go down to the river to fetch water and falls asleep on the river bank. While he is asleep he dreams he has become very tiny. Then all the dirt in and near the river, becomes, to him, very frightening. He battles his way through it and at last wakes up . . . and decides to try and stop the pollution of his water supply.

2. The Water Dirtiers

A story of how some powerful and selfish people in the community made the water source dirty with their animals and by throwing waste in it . . . How the children found out and took action to stop them (or get the villagers to stop them).

3. The End of a Happy Life

A story told by the germ family of how the very happy life which they and their friends used to live in and round the water source, became gradually less and less comfortable as the children began to follow new ways of keeping their water clean. In the end the germ family was forced to move house to a new and dirtier place.

DRAMA; MIME; DANCES; PUPPETS

These stories and others can be dramatised. Remember children can take parts of animals, insects, even things as well as people. In the Water Dirtiers story, for instance, children can act *Grown Up People, *Cows. *Flies, *Children, *The fence the villagers put up around the water supply, *The water supply itself. The other two stories are both excellent for turning into mime or dances or puppet plays.

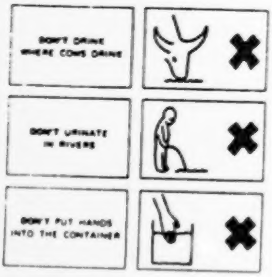
PICTURES AND FRIEZES

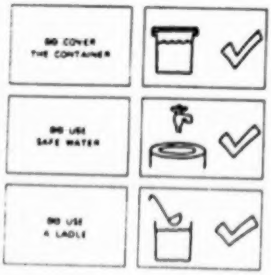
All these stories are very good subjects for pictures made by a group of children. Some children paint the background and the others add different things onto the pictures and stick them on. Remember, you can use cloth or leaves or stones or any other kind of material to make your picture more interesting. A **Frieze** is a series of pictures which tell the story. Different children draw pictures and others write the story underneath. A group picture or frieze need not be connected with a story. It could be a topic or sequence . . . "Safe Water", or "Collecting clean safe water and bringing it home".

POSTERS; GAMES; PUZZLES

Here are some very simple ideas that can be incorporated into posters . . . but there are many others. These pictures and others like them can be used to make;

- **Cards for matching (Picture and Text)**
- **Dominoes**
- **Fit together puzzles**


DON'T DRINK WHERE COWS DRINK
DON'T URINATE IN RIVERS
DON'T PUT HANDS INTO THE CONTAINER



Example II An Activity Sheet Adapted to Suit Local Needs
(Gujarat, India) (page 1 of 2)

MALARIA

The Idea

The incidence of malaria is very high in Gujarat. Children as well as adults often get malaria. Malaria is caused by a mosquito bite. If the spread and incidence of mosquitoes can be controlled malaria can be prevented. Children can help to prevent malaria.

How Does Malaria Spread:

Malaria is spread by mosquitoes. If a mosquito bites a person suffering from malaria, and then bites another person, that person can get malaria.

Symptoms:

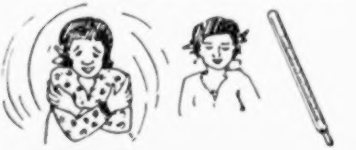
The person feels very cold and gets shivers prior to onset of fever.

Then, the fever decreases on its own.

There is profuse perspiration after the fever comes down.

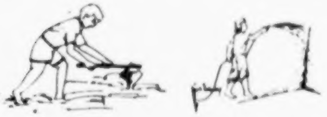
The fever of malaria occurs every alternate day. Sometimes it comes daily and often it comes at approximately the same time.

Acute weakness is one result of malaria.



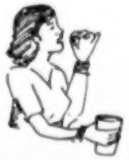
Prevention:

To prevent malaria, the growth and spread of mosquitoes should be stopped. Larvae of mosquitoes which spread malaria grow in clean, stagnant water puddles. Such puddles should be filled up. The house should be sprayed regularly with insecticides.



Cure:

To cure malaria a course of ten CHLOROQUINE tablets should be taken. Even if the fever subsides the entire course of the tablets should be completed. If the course is not completed, the fever may reoccur.

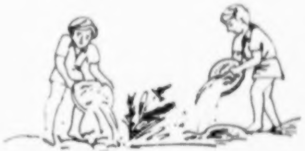


How Can Children Help?

Children can help in preventing and curing malaria.

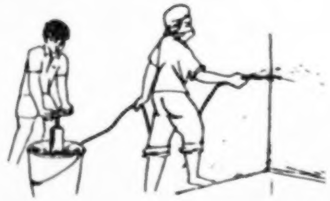
Preventing

1. If there are any puddles of stagnant water around the house, these should be filled up by mud by the children.

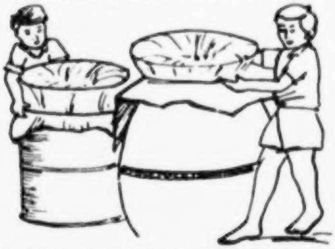


2. If there are big ponds of water, oil (e.g. the oil from a tractor), can be put in it to prevent the growth of mosquitoes.
3. If 'gambuchi' fish are available in the area, the children can go directly to the health worker concerned and request them to introduce such fish in to the pond.
4. Children can help the health worker to distribute medicine.
5. When the malaria worker comes to the village to spray insecticides, the children can help in spraying and also show the malaria worker the puddles and ponds of the village where stagnant water has collected and have them sprayed too.

Example II Malaria (page 2 of 2)



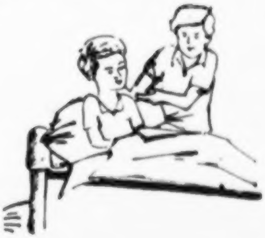
6. When the walls of the houses are sprayed, the insecticide should be allowed to remain on the walls, so that when mosquitoes sit on the walls, they will be killed by the insecticides. Sprayed walls should not be plastered over with cow dung or wiped by a cloth otherwise the insecticide will be useless. Children can take care that this is adhered to.
7. Burn neem leaves in the house to smoke out mosquitoes.
8. If water is stored in drums or earthenware pots, they can be covered with cloth by the children to prevent the growth of mosquitoes in them.



9. Mosquito nets can be used for the beds. The older children can remember to do this every night and help in tying the net.
10. If malaria is highly rampant at any place, in order to prevent malaria, weekly preventive dose of chloroquine tablets should be taken. Children can help health worker to distribute this medicine.

Curing

1. Children can find out who all in their area are suffering from malaria, they can pass on this information to the village health worker, and help the patients to get the medicines.
2. If some people are suffering from malaria in the village, a child can go and call the health worker or the malaria worker to the village.
3. Older children can help to nurse younger brothers and sisters suffering from malaria and remind the elders to give medicine on time.



How Can This Message Be Spread?

Puppet show, songs, dramas, stories, etc. can help give education about malaria.

Finding Out How Well the Activities Worked:

1. Inspect around the houses of the village to see if there are any filled puddles or not.
2. See if the people have their houses sprayed regularly or not and whether they allow the insecticide to remain on the wall or wipe it away.
3. See whether a cloth is tied over drums or earthenware pots used for storing water.

Who Can Use This Activity Sheet?

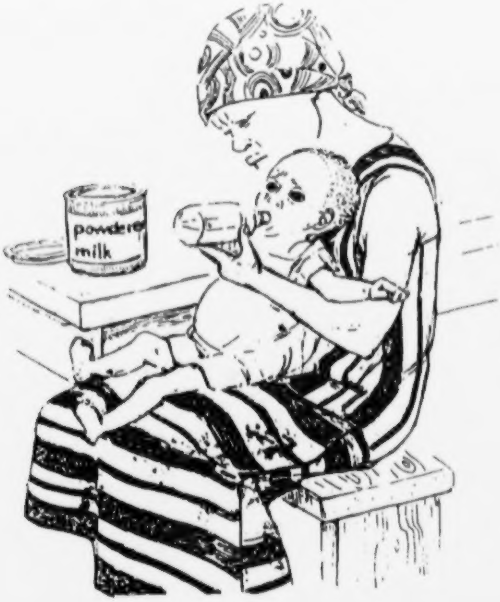
Teachers, health workers, members of women's and youth organizations, etc.

Example III Specimen Pages from Child-to-Child Story Books

1 From "Good Food" (in a restricted vocabulary of 500 words)

Mrs Bulbul does not give Wawa her milk. She gives him milk from a tin. She buys the tin in the shop. The tin always costs a lot of money. Milk from a tin is not very good for babies. Mrs Bulbul does not know this.

Wawa is thin and ill. He is not happy because he does not get milk from his mother. He does not get mashed food. He does not get cooked food. He does not get different food. He only gets milk from a tin.



Example III cont.

2 From "Down with Fever" (in a more extended vocabulary of 1,500 words)

Sara continued to cry. "It hurts!"

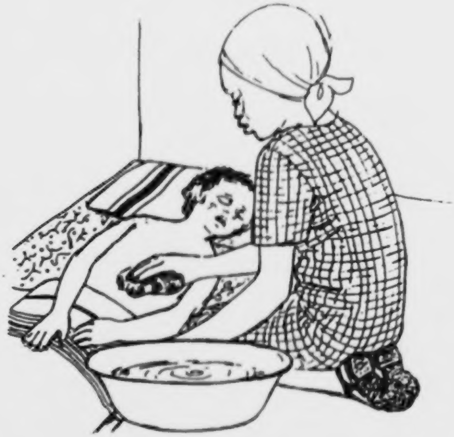
"Where does it hurt?"

"Here!" Sara put her hand on her head. "I feel bad!" she cried.

Ruth called to Rebecca. "Will you look after my brothers for me? I think Sara is sick. I am taking her home."

"All right," said Rebecca. "Don't worry."

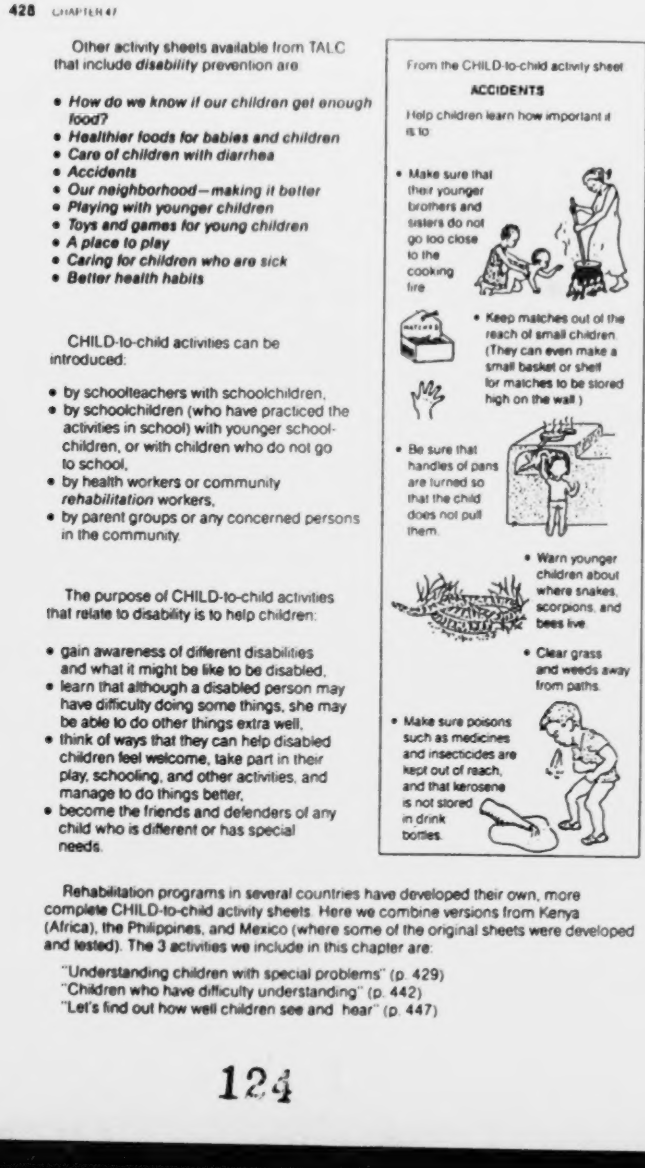
Ruth took Sara home. Her mother and aunt were away at the market. Sara had a hot forehead. Her clothes were wet. "That must be sweat," Ruth thought. "I must wash her."



She washed Sara in cool water. Then she dressed her in clean, dry clothes.

Example IV Incorporation of Material in Other Publications

From "Disabled Village Children" by David Werner



Other activity sheets available from TALC that include ***disability*** prevention are

- ***How do we know if our children get enough food?***
- ***Healthier foods for babies and children***
- ***Care of children with diarrhea***
- ***Accidents***
- ***Our neighborhood—making it better***
- ***Playing with younger children***
- ***Toys and games for young children***
- ***A place to play***
- ***Caring for children who are sick***
- ***Better health habits***

CHILD-to-child activities can be introduced:

- by schoolteachers with schoolchildren,
- by schoolchildren (who have practiced the activities in school) with younger schoolchildren, or with children who do not go to school,
- by health workers or community *rehabilitation* workers,
- by parent groups or any concerned persons in the community.

The purpose of CHILD-to-child activities that relate to disability is to help children:

- gain awareness of different disabilities and what it might be like to be disabled,
- learn that although a disabled person may have difficulty doing some things, she may be able to do other things extra well,
- think of ways that they can help disabled children feel welcome, take part in their play, schooling, and other activities, and manage to do things better,
- become the friends and defenders of any child who is different or has special needs.

From the CHILD-to-child activity sheet

ACCIDENTS

Help children learn how important it is to:

- Make sure that their younger brothers and sisters do not go too close to the cooking fire.
- Keep matches out of the reach of small children. (They can even make a small basket or shelf for matches to be stored high on the wall.)
- Be sure that handles of pans are turned so that the child does not pull them.
- Warn younger children about where snakes, scorpions, and bees live.
- Clear grass and weeds away from paths.
- Make sure poisons such as medicines and insecticides are kept out of reach, and that kerosene is not stored in drink bottles.

Rehabilitation programs in several countries have developed their own, more complete CHILD-to-child activity sheets. Here we combine versions from Kenya (Africa), the Philippines, and Mexico (where some of the original sheets were developed and tested). The 3 activities we include in this chapter are:

"Understanding children with special problems" (p. 429)
"Children who have difficulty understanding" (p. 442)
"Let's find out how well children see and hear" (p. 447)

Example IV cont.

From "Primary Health Education" by Beverly Young and Susan Durston

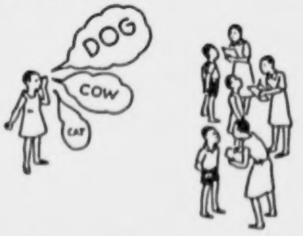
Check how well children can hear

Here are some signs to look for:

- the child speaks rather loudly
- he turns his head in one direction in order to hear
- he fails to answer questions because he does not seem to hear
- the child watches people's lips when they are talking
- sometimes a child appears to be quiet, sullen, even rude (it may be that he does not hear well and needs help)

As for testing sight, it may be a good idea to test children's hearing, particularly when they first come to school. Here is a possible way to do it, using older children as helpers:

1 The children being tested stand in a semicircle. An older child stands by each younger one. Each older child has a pencil and paper.
2 An older child stands at the centre of the semicircle. He should be several metres from the younger ones.
3 The older child then calls out the name of an animal very loudly.
4 Each younger child whispers the name to his helper who writes it down.
5 The older child again says the name of other animals. Each time he says the name he makes his voice softer, until he is whispering.
6 The young children tell their helper what they hear. The helpers write it down.
7 After about ten animals, the helpers compare their lists to see what the younger children have heard.



If any child has heard fewer names than others, he may have a hearing problem. Let him sit at the front of the class. If possible, he should be examined by a health worker especially if he has pus in an ear or frequent earache.

Check that children have been immunised

- Make sure that children have been immunised. The serious diseases against which children can be protected by immunisation are described on page 87. The local health worker or doctor should be able to cooperate with the school to ensure that an immunisation programme is organised at the school. Care will be needed to manage such a programme as the polio vaccine, for example, has to be given three times. Careful records should be kept.

APPENDIX 2

FIFTY EXAMPLES OF CHILD-TO-CHILD ACTIVITIES FROM AROUND THE WORLD

Child-to-Child with Ministry of Education in Primary Schools

India (New Delhi)

Sponsored by the National Council for Educational Research and Training, Child-to-Child approaches are introduced into 32 schools in the municipality in order to develop approaches which can be used subsequently in all schools. Emphasis is on 14 key health messages and on standards 4 and 5. Activity methods are stressed. There is a parallel project on early childhood education in these schools (4 and 5 year olds) and the two projects are conceived as supporting each other.

Contact: Dr Sheila Vir, Education Officer, UNICEF House,
73 Lodi Estate, New Delhi 110003, India.

Papua New Guinea

Child-to-Child approaches have been incorporated into the Community School syllabus, which emphasises health education. The approach also emphasises the relation of school to community and the responsibility of children. One example is publication by the Ministry of Education of a booklet "Finding out about our school: Is it Healthy?". Children and teachers have a checklist which they fill out each week, month and term.

Contact: SCO Health, Curriculum Division, Ministry of Education,
Department of Education, PSA Haus, PMB, PO, Boroko, Papua New
Guinea.

Tanzania

A new school health programme emphasising Child Survival and development has been launched by the Ministry of Education with support from UNICEF. (Similar programmes exist in other East African countries). Child-to-Child approaches have been incorporated into this programme and into the teacher training which accompanies it. Schools use a translation of Child-to-Child materials in Swahili and also Child-to-Child readers in their English lessons.

Contact: Programme Officer Health, UNICEF, PO Box 4076, Dar Es Salaam, Tanzania.

Zambia

There are national and local Child-to-Child committees throughout the country, with participation from both Ministries of Education and Health. Local committees have considerable autonomy to adapt approaches in schools. Child-to-Child concentrates particularly on certain key health priorities, e.g. oral rehydration, immunisation, nutrition; and emphasises the use of children as information gatherers and communicators within their local areas.

Contact: Mambo Mwenda, Director, National Committee on Child-to-Child, Ministry of General Education and Culture, PO Box 500093, Lusaka, Zambia.

Child-to-Child beyond Health Education

Chile

The Child-to-Child programme, instituted through the Ministry of Education and initially centred on health education, uses 12 and 13 year old children as "helpers" with younger children in rural schools. Each older child has about seven young ones to help. Now help has been extended to basic skills and value education. Such success has been observed for the programme, particularly upon the "helpers" themselves, that 1 1/2 million children are now affected and all schools in Chile will be involved in 1988. Much supporting material is produced.

Contact: Professor A. Schuster Cortes, Professor of Paediatrics, University of Chile, Barcelona 2018 Apt. 305, Santiago, Chile.

Child-to-Child School Programmes - with the Ministry of Health

Liberia

A locally-produced Child-to-Child booklet is issued by the Ministry of Health and used with schoolchildren. The Child-to-Child readers prove useful, and children are encouraged to re-tell the stories to their parents.

Contact: Esther M. Moore, Ministry of Health and Welfare, PO Box 9009, Monrovia, Liberia.

Nepal

Materials and approaches are used extensively by the Health Education unit of the Urban Development Programme in Kathmandu. Children in schools are initiated into the activities by their teachers. They form teams and take the messages to younger children in school, to children outside school and to their families and communities. Some 10,000 children are said to be involved.

Contact: Kamal Shrestha, Health Education Programme, PAS Urban Development Unit, Ward No.2 SANEPA, Lalitpur, PO Box 1456, Kathmandu, Nepal.

Oman

Following a national seminar organised at the Ministry of Health plans are now being developed to spread the ideas widely through the schools system. Ministries of Education and Culture as well as UNICEF and other voluntary agencies are all co-operating.

Contact: Dr Hassan Bella, King Faisal University, Colleges of Medicine and Medical Sciences, PO Box 2114, Damman, Kingdom of Saudi Arabia.

Zimbabwe

Activities are being undertaken both nationally and provincially. In one province teachers are encouraged to include activities in their social studies teaching; at the same time the materials are reproduced informally through the school health magazine as a resource for all teachers.

Contacts: Health Education Officer, Health Education Unit, Provincial Health Authority, Mashonaland West, Box 139, Chinhoyi, Zimbabwe and Health Education Officer, Health Education Unit, Provincial Health Authority, Manicaland, PO Box 323, Mutare, Zimbabwe.

(In *Bangladesh* such a health magazine, "Mitali", produced by UNICEF and specifically aimed at children who take care of their younger brothers and sisters, includes many Child-to-Child activities.)

Contact: Programme Communication and Information Section, UNICEF, House No. 52, Road No. 4A, Dhanmonid RA, GPO Box 58, Dhaka, Bangladesh.

Child-to-Child Activity Parallel to National Programmes

Uganda

An association of Child-to-Child schools exists organised by a committee of teachers with funds provided mainly from a group of parallel schools in Norway. Child-to-Child schools carry out particularly health-based activities within those schools and in the community, and produce materials: a calendar, a children's magazine, a book written by the children; and teachers produce radio programmes, and carry out health promotion campaigns with their communities.

Contact: Violet Mugisa, Chairperson Child-to-Child, c/o UNICEF, PO Box 7047, Kampala, Uganda.

Guatemala

A Child-to-Child programme emphasises not only health messages but the importance of children within the educational system (and their rights within it). Much material is produced, including a newsletter and comic strips as well as books of writing by children which can be used as reading material for other children. Children also take part in radio broadcasts.

Contact: Sr Israel Perez, Programa Latinoamericano Niño-a-Niño, Apartado Postal 24-E, Zona 21, Ciudad de Guatemala.

Burkina Faso

A co-ordinating Child-to-Child unit with permanent staff has been set up to service and assist different initiatives undertaken by government, ministries and voluntary agencies. Such a unit also initiates and organises training but in no way "directs" Child-to-Child.

Contact: Françoise Faivre, Bureau L'Enfant pour l'enfant, Ouagadougou, Burkina Faso.

Voluntary Agencies and Child-to-Child

Pakistan

The Aga Khan School Health Service provides Child-to-Child material to both teachers and social workers, and has prepared much additional material. Some 12,000 school children are affected. The Aga Khan Foundation in partnership with UNICEF also gives substantial support to six programmes in India.

Contact: Dr Afroze Ramzan, The Aga Khan School Health Service,
515 Gold Street, Karachi, Pakistan.

Sierra Leone

Plan International, a community development and foster parents agency, produces its own local versions of Child-to-Child material especially aimed at family welfare, trains teachers, organises talks and plays by groups of children and maintains a monthly "reporting session" by siblings on the growth and development of their younger brothers and sisters based on the "under five" clinic card.

Contacts: T.E.A. Macaulay, Chief Health Education Officer,
Health Education Department, Ministry of Health, Freetown,
Sierra Leone
and Smart T. Rogers, PLAN International, PMB 245, Freetown,
Sierra Leone.

Child-to-Child in Single Institutions

Ang la (for example)

"The children surrounding the Bongo Mission hospital were gathered once a week for three months in the village church and presented with different topics of Child-to-Child activity sheets, in order to put into practice and to influence their parents and brothers ..."

Very often individual teachers and health workers report Child-to Child activities based on schools, colleges and clinics and many very original ideas emerge, e.g.

Ghana

Children take lead in environmental sanitation.

Senegal

They help at the clinics.

India (Andhra Pradesh)

They plant and care for fruit-bearing trees.

...and there are many, many more examples.

Child-to-Child and Specific Target Groups

i. Pre-School Children

Botswana (described in Chapter 3)

The Child-to-Child Foundation works with a growing number of schools and identifies schoolchildren in school who are given the special task of "readying" children of pre-school age for school. This benefits both the younger children and the "little teachers".

Contact: Mrs L. Masolotate, Child-to-Child Foundation, PO Box 0084, Gaborone, Botswana.

Jamaica

Following a research project organised by the University of the West Indies, a Child-to-Child workshop was held to stimulate toy making by older for younger children ... Many ideas were collected and have been incorporated into school programmes. Guidelines for toy making and use were evolved. Elsewhere (e.g. Java, Indonesia) school children in upper classes have been successfully used to make play material for children in lower classes and pre-school groups.

Contact: S.M. Grantham-McGregor, Tropical Metabolism Research Unit, University of the West Indies, Mona, Jamaica.

ii. Handicapped Children

Mexico

Project Projimo is a community-based project for the disabled organised in Western Mexico. Project members, themselves usually disabled villagers, co-operate to make aids for disabled children. Child-to-Child collaboration is constantly stressed and many of the project workers are children and young people. The project is described in Werner's *Disabled Village Children*.

Contact: Martin Reyes Mercado, Ajoya, San Ignacio, Sinaloa, Mexico.

Honduras

Students in the Department of Special Education in one of the Teachers' Colleges (Escuelas Normales) are taught how to help school children who are not handicapped make apparatus for those who are.

Contact: Francy de Avila, Depto de Educación Especial, Escuela Normal "España", Villa Ahumada, Danli, El Paraîso, Honduras, América Central.

Kenya

A number of schools stimulated by the charity Action Aid (which also organises similar programmes in other countries) have taken action to help local handicapped schools and children. Child-to-Child material has been specially adapted.

Contact: Action Aid Kenya, PO Box 42814, Nairobi, Kenya.

India (Andhra Pradesh)

From 1982 activities have been organised in Tirupati with "child leaders" identified to spread messages in schools, families and communities in the slum areas. A particular emphasis is being placed on the identification and prevention of eye disease (xerophthalmia and angular stomatitis) and even more so on the causes of these: poor nutrition, failure to immunise, poor personal hygiene. The programme has received funding from the Royal Commonwwealth Society for the Blind.

Contact: Dr Annand, SV Medical College Campus, Tirupati 517507, India.

iii. Refugee Children

Djibouti

Child-to-Child material was used to teach children attending feeding centres in refugee camps ... at the same time community health workers were inducted into the use of Child-to-Child messages for children in the villages.

Contact: Save the Children Fund (Somalia), c/o WFP/PAN, BP 2001, Djibouti, East Africa.

Somalia

At a Child-to-Child seminar (1986) follow-up activities have been designed for refugee children. These are now being monitored. Child-to-Child activities are also being used with refugees in *Lebanon; Thailand; Pakistan* (for Afghan refugees).

Contact: Bashir Kahiye, IITT, PO Box 3490, Mogadishu, Somalia.

iv. Street Children and Other Displaced Children

India (Bombay)

The Mobile Creche programme is set up for the children of migratory workers who have come to Bombay in search of work. Fathers and mothers work often on construction sites for short periods. Children in mobile creches are of different ages and backgrounds. The Child-to-Child approach in and beyond health education is exceptionally effective with children learning to help and learn from each other in small groups.

Contact: Dr Indu Balagopal, Mobile Creches, Res Samudra Mahal, Worli, Bombay 400018, India.

Philippines (Manila)

The LINGAP centre in Manila gives alternative education for street children and abused children. Children work in groups of 10 to 12 with games, role playing and group sharing. They learn to help each other and to apply the Child-to-Child messages outside the centre.

Contact: Roselle Leah K. Rivera, LINGAP Centre, Welfareville Compound, Mandaluyong, Metromanila, Philippines.

Brazil (Itabuna Municipality)

"Children's farms" have been established for street children organised by the Mayor and his wife (one of the original founders of the Child-to-Child programme in Brazil). Children of all ages work together.

Contact: Professor Maria Rita Dantas, Av. Princesa Isabel 125, Apt. 704, 40-000, Salvador, Bahia, Brazil.

v. Children in Hospital

India (Baroda)

Older children in the paediatric ward made puppets and read stories to the younger ones. After leaving they were encouraged to take Child-to-Child messages back to their villages.

Contact: Professor T.S. Saraswathi, Department of Child Development, Faculty of Home Science, MS University of Baroda, Baroda 390002, India.

Similar activities are reported from *Kenya (Northern Province)* where children in hospital wards have been encouraged to read and translate the Child-to-Child readers to younger or non-school children.

vi. Children in Remote Areas

India (Maharashtra)

Children of health workers who travel into tribal areas are taught to regard themselves as child health workers to work with local children. Qualities of tact, understanding and humility are particularly emphasised so that they, like their parents, will be trusted and accepted.

Contact: Sujata Kaushik, Baif Kadhenu, Senapati Bapat Marg, Pune 411016, Maharashtra, India.

vii. Children in Inner City Slum Areas

A number of programmes have been organised using children as health educators and communicators.

India (Bombay)

The Malvani project, described in chapter 4, uses child volunteers in classes to emphasise health priorities and outside them as outreach workers. The project described above in Tirupati also works in a similar way in disadvantaged areas.

Contact: Dr V.R. Bhalerao, Professor and Head of Preventive and Social Medicine, G.S. Seth Medical College (and KEM Hospital), Parel, Bombay 400012, India.

Kenya (Nairobi)

A troop of Health Scouts, working from a community centre in Mathare valley, was able to spread health messages particularly through the use of songs. Similar programmes are described in *South Africa*.

See: Menczer, J. and Davis, P. (eds.) *Child-to-Child - Health in Kenya* (Jigsaw series). Oxford: OXFAM, 1981.

Child-to-Child through Scouts and Health Scouts

Nigeria

The Boy Scouts of Nigeria use Child-to-Child activities in various States. Emphasis is particularly on community hygiene and safety aspects of the programme. Training is given as well as awards for proficiency. Similar activities are reported from the People's Republic of *Benin*.

Contact: Alh Bala M. Bello, Assistant National Training Commissioner, Boy Scouts of Nigeria, PO Box 6311, Jos, Plateau State, Nigeria.

Sudan

Secondary school pupils (11 to 13) in the Eastern and Northern Gezira Province operate a Health Scout project under the direction of an area co-ordinator. Each school is divided into Health Scout committees under the supervision of a master. Each committee takes an area and each pupil three families. They are then responsible for teaching and monitoring certain key health priorities within these families.

Contact: Dr Hassan Mohamed Ahmed, Paediatrician, University of Gezira, Medina, Sudan.

Indonesia (Jakarta)

A "little doctor" programme is in operation. Children in school are specially selected to receive "little doctor" status. Once they are appointed they work to the school health officer and have certain specific duties. They must also keep records of community hygiene and report findings.

Contact: Chief Medical Officer, Jakarta Municipality, Jakarta, Indonesia.

Similar Health Scout programmes are reported in *Peru* and *Pakistan*.

Child-to-Child in Medical Training Programmes

Indonesia (Semarang)

In the Department of Community Health in the Faculty of Medicine all students have to study and discuss Child-to-Child approaches. The use of Child-to-Child also forms part of their practical training. A team from the faculty has adapted Child-to-Child material to suit the particular context and purpose of the training.

Contact: Professor Moeljono S. Trastotenojo, Rector, Diponegoro University, Semarang, Indonesia.

Nigeria (Lagos State)

Child-to-Child activities are integrated into the programme for teaching medical students and community health care officers at the Institute of Child Health and Primary Care at the College of Medicine, University of Lagos. The College maintains contacts with local primary schools and tries out materials there. Children also gather information about health problems under the direction of the Institute.

Contact: Catherine Olukemi Agbede, Institute of Child Health and Primary Care, College of Medicine, University of Lagos, PMB 12003, Surulere, Lagos, Nigeria.

Tanzania (Zanzibar)

Child-to-Child activities and approaches are used in the training of nurses. Because of the educational and language levels of the nurses it has been found that the Child-to-Child readers are a very suitable means of conveying messages to them.

Contact: Shirley Dabek, PO Box 341, Zanzibar, Tanzania.

In *Sri Lanka* Child-to-Child is similarly used in university-based training for child care workers.

Further Information

All of the above examples illustrate types of activity which might constitute a Child-to-Child programme; it is not a comprehensive list. If you would be interested in further information or materials please contact the Child-to-Child Co-ordinating Office at the London University Institute of Education, 20 Bedford Way, London WC1H OAL, United Kingdom ... we would be happy to hear from you.

Some Additional Reading

On Educational Approaches:

International Commission on the Development of Education (chaired by Edgar Faure). *Learning to Be: The World of Education Today and Tomorrow.* Paris: Unesco, 1972.

Dave, R.H. *Lifelong Education and School Curriculum.* Hamburg: Unesco Institute for Education , 1973.

Ingram, J.B. *Curriculum Integration and Lifelong Education.* Oxford: Pergamon Press and Unesco Institute for Education. 1979.

Cummings, W.K. *Low-Cost Primary Education: Implementing An Innovation In Six Nations.* Ottawa: International Development Research Centre, 1986.

Flores, P.V. *Educational Innovation in the Philippines: A Case Study of Project Impact.* Ottawa: International Development Research Centre, 1981.

Gartner, A. et al. *Children Teach Children: Learning by Teaching.* New York: Harper and Row, 1971.

Botkin, J.W. *No Limits to Learning. A Report to the Club of Rome.* New York: Pergamon Press, 1979.

On Health Priorities:

Morley D. and Lovel H. *My Name is Today.* London: Macmillan Publishers Ltd., 1986.

Morley D. *Paediatric Priorities in the Developing World.* London: Butterworths, 1973.

King M., King F. and Matodipeoro S. *Primary Child Care.* Oxford: Oxford University Press on behalf of the World Health Organization, 1978.

Werner D. *Where There Is No Doctor.* London: Macmillan Publishers Ltd., 1979.

UNICEF. *The State of the World's Children 1988.* New York: Oxford University Press for UNICEF, 1988.

Hubley J.H. "Barriers to health education in developing countries." *Health Education Research - Theory and Practice.* Vol.1 (1986) No.4., pp. 233-245.

Books Incorporating Child-to-Child Approaches:

Young B. and Durston S. *Primary Health Education.* Harlow: Longman, 1987.

Aarons A. and Hawes H. with Gayton J. *Child-to-Child.* London: Macmillan Educational Ltd., 1979.

Werner D. *Disabled Village Children.* California: The Hesperian Foundation, 1987.

Werner D. and Bower B. *Helping Health Workers Learn.* California: The Hesperian Foundation, 1982.

Edwards P. et al. *Child-to-Child Readers.* Harlow: Longman, 1985.

Carlile J. and Martin J. *Toys for Fun - A Book of Toys for Pre-School Children.* London: Macmillan, 1988.